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The New York
Academy of Medicine

By Exchange

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY UNDER THE DIRECTION
OF THE COMMITTEE ON PUBLICATION



Volume XXX.

January, 1933--December, 1933

Committee on Publication:
Drs. Henry C. Barkhorn, Edward J. Ill, Linn Emerson,
Frederic J. Quigley (ex-officio) J. Bennett Morrison (ex-officio)

14 South Day Street, Orange, N. J.

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Special Economics Number

THE JOURNAL

OF THE

Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 1 Orange, N. J., January, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

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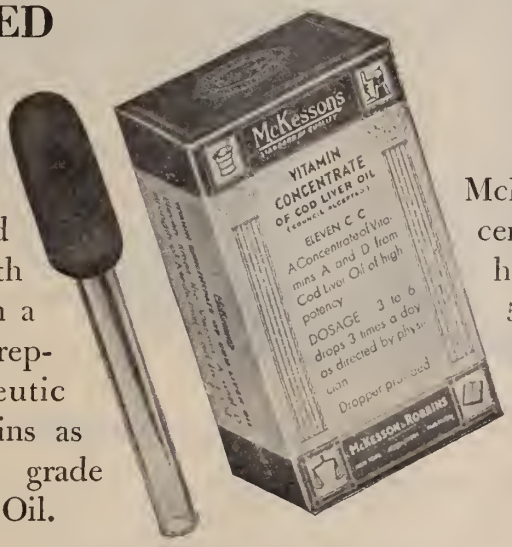
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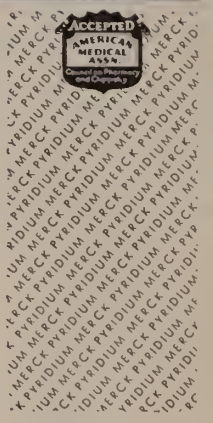
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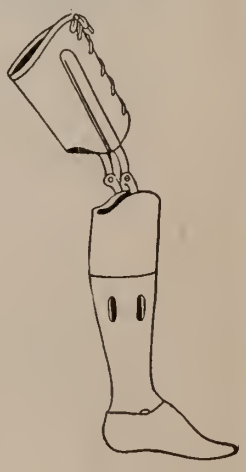
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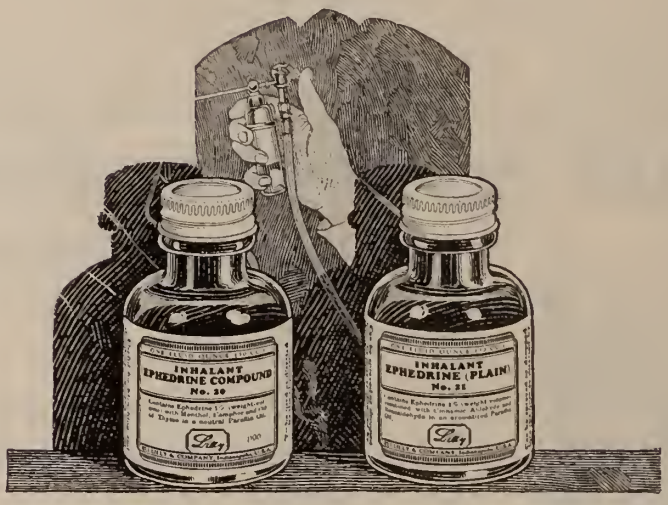
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Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Vol. XXX., No. 1 ORANGE, N. J., JANUARY, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

SIMPLE METHOD OF PELVIMETRY BY ROENTGENOGRAPHY

J. Harris Underwood, M.D.,
Woodbury, N. J.,
and
Elwood E. Downs, M.D.,
Woodbury, N. J.

Advantages of exact measurement of pelvic inlet. The obstetrician recognizes 2 important factors in the production of dystocia, namely the size of the passenger and that of the passage-way.

For some time we have been specially interested in determining the exact measurements of the pelvic inlet; the pelvic outlet, being usually in proportion to the inlet, causes little concern. Since abnormality of size and shape of the pelvic inlet are responsible at times for fetal as well as maternal mortality and morbidity, it behooves us to determine measurements as accurately as possible, and at a date early enough to allow thoughtful consideration of safe delivery methods. A contracted or misshapen pelvis may not permit the safe passage of an average sized infant, while an induction of premature labor, or cesarean section, may result most happily for mother and child. On the other hand, labor may, in some cases, be allowed to proceed normally if we have accurate knowledge of internal dimensions which without this information would appear abnormal and to be treated surgically.

Method of estimating measurements. Our method is quite similar to that of Thoms, although we had employed this technic prior to acquiring knowledge of his article.

The patient is placed on the Bucky table, in a semi-recumbent position and at such an angle that the superior strait of the pelvis will be on a plane parallel to the cassette which is inserted in the tray beneath the grid. This angle will vary in different patients but can easily be determined by: (1) marking the skin at a point between the fourth and fifth lumbar vertebras posteriorly, and (2) then dropping a rule perpendicularly to the table from the superior surface of the symphysis pubes. The patient should then be adjusted so that the distance between the mark on the skin posteriorly and the table will equal that of the measurement from the pubes to the table; and this distance should be recorded. The Roentgen-ray tube is next centered in the median line, 5 cm. posterior to the upper border of the symphysis. A film-target distance of 75 cm. is used. After the exposure is made, move the patient from the table with the tube and film *in situ*. Our apparatus is then placed on the table directly beneath the Roentgen-ray tube; the metal indicator is elevated to a height corresponding to the measurement previously noted (the distance between the superior surface of the pubes and the table); and, a flash exposure made. The centimeter notches on the rule can be seen plainly on the film after development, being enlarged in exact proportion to the magnification of the superior strait, and with the bony landmarks visible, and the *conjugata vera* transverse, the right and left oblique diameters are readily obtained.

Description of Apparatus

Our measuring device consists of a piece of ply-board 17 x 17 inches. On this are fastened 2 sheets of lead 8¼ x 17 in. and 1 mm. thickness. These are placed parallel, one to the other, leaving a space 8 mm. in width through the center of the board without lead protection. At either end of this unprotected line uprights are fastened. In these are slits to permit the attachment of an adjustable metal rule, in which are notches 1 cm. apart; the fifth and multiples thereof being deeper to facilitate calculation. The shadow of this notched rule will be projected on the film through the space between the lead plates. On both uprights are centimeter markings representing the distance of the rule from the table.

This apparatus is not cumbersome. It weighs only 7 lb. and can be adjusted with rapidity and precision.

Conclusion

We feel that, as compared with other methods of x-ray pelvimetry, this is the simplest. While it need not be routine with all patients, it should be routine with all primiparas where external pelvic measurements are at all abnormal, and in multiparas with a history of difficulty in previous deliveries.

The technic is carried out with a minimum of effort for the obstetrician and the least possible inconvenience and exposure of the patient.

CERVICAL INFECTIONS

Thomas B. Lee, M.D., F.A.C.S.,
Camden, N. J.

Cervical infections are said to be the most common of all gynecologic disorders (Polak). The acute infections subside so quickly, or pass into the chronic forms of the disease, that they are rarely seen by the clinician. This paper concerns itself with the consideration of "chronic cervicitis", excluding cases due to tuberculosis or syphilis.

The most common macroscopic evidence of cervicitis is the so-called "erosion" seen on the vaginal part of the cervix. This is red, bleeds easily, and is rough but not friable. It is brought about by an increase in the cervical mucus, mucopurulent from infection which macerates and denudes the surface, leaving little islands of the more resistant epithelium. The cylindric epithelium of the canal, being more resistant to these conditions, grows down over the raw area. If infection and discharge subside, as they may do spontaneously, the squamous epithelium regains its vitality and pushes the columnar tissue back toward the cervical canal. Blocked-off glands cause the cysts of Naboth.

Such a condition, though resulting in a cure, may and often does recur, especially if any degree of laceration and eversion exists. Hypertrophy of the cervix and distortion of the external os occur in most cases of any severity and increase with recurrent attacks. A patient seen by the author a few years ago, an undoubted virgin with a history of long-standing leukorrhea, presented a perfect picture of deep bilateral laceration of the cervix. She married later but has remained sterile to date. Less often, the vaginal part of the cervix remains unaffected, the disease being confined to the cervical canal glands; the cervical mucus is cloudy, contains many bacteria and leukocytes, and its pH reaction seems but little altered.

Etiology. Here we must consider several important factors: (1) That the vagina is, under ordinary circumstances, grossly infected. (2) That the cervical canal, as shown by Curtis and others, is only slightly infected —the infections ceasing altogether under normal conditions at the internal os. (3) That according to Bland, Williams and many others, no woman passes through even a normal labor without some damage to the cervix.

Since infection is omnipresent, and since some laceration is inevitable in labor and abortion, it would seem accidental indeed if some degree of infection did not result unless prophylactic measures be taken.

The gonococcus must be a frequent infecting agent although Norris states that a true macroscopic erosion due to gonorrhea is extremely rare. Hess regards vulvovaginitis in children as always involving the cervix. Rubin

believes that vulvovaginitis in children is usually not gonorrheal and that the cervical canal is more often infected than is ordinarily believed. Graves states that the micrococcus in the tissues is indistinguishable from the gonococcus and intimates that the gonococcus is not the etiologic factor as often as was formerly supposed.

The contraceptive stem-pessary, and the various instruments used in criminal abortion, must be mentioned as causes. Trichomonas vaginalis, now so commonly found, at times invades the urethra, Skene's glands and Bartholin's glands, but is never found in the cervix, according to Kleegman.

To sum up regarding etiology, we may say that although cervical infection may be caused by other factors it is generally accepted that the most frequent cause is the laceration of labor or abortion, with subsequent infection, and as expressed by Sturindorf the incidence of infection is the dominating factor.

Sterility. Cervicitis as a cause of sterility has received much attention, and deservedly so. In 100 patients with cervicitis studied by the author prior to 1927, all of whom had suffered from leukorrhea of several years' duration and all of whom came to abdominal operation, 30% were sterile. In all of these cases the tubes were patent and demonstrable adnexal disease absent. None was of the endocrine type. Polak and Frank recognize cervicitis as the chief cause of sterility. Reynolds and McComber believe that few women who have a complete attack of gonorrhea ever conceive. But this, like most rules, has some exceptions. The more important cases are those nonspecific infections—obstetric, instrumental, or marital—probably by colon bacillus, in which the onset is so mild as to escape detection. These are usually limited to the canal. The cloudy mucus, heavy with leukocytes, makes the diagnosis. This explains many of the 1-child sterility cases. In women whose tubes are patent, the sex hormone present in sufficient quantities in blood and urine, and the menses normal, attention to even slight cervical abnormalities will often result in impregnation. The only satisfactory results we have had in the treatment of sterility have been in this class of patients.

Leukorrhea. It is quite generally agreed that long-standing leukorrhea is most often the result of cervicitis. Indeed, this most common of gynecologic symptoms usually indicates this most frequent of pelvic disorders. Disease of Bartholin's and Skene's glands must be eliminated, also vaginitis in the aged and that due to Trichomonas vaginalis, which has been so completely studied by Bland and his associates. It should also be mentioned that leukorrhea of cervical origin may occur as a result of constitutional conditions which cause increase in flow of mucus; also, a profuse leukorrhea is, without doubt, a debilitating condition.

The cervix has been many times brought into the "lime light" as a point of focal infection, especially in producing secondary lesions in the skin or eyes, and it is frequently compared to the prostate gland and the tonsils. Cases are reported in which chronic arthritis followed chronic cervicitis. However, plastic work, or the cautery, or even amputation of the cervix, has been to us very disappointing for relieving such remote lesions, when they and cervicitis were co-existent. Whether these contentions will be proved remains to be seen, but the fact that the cervical infections act as a focus of infection to the other pelvic organs seems established; post-parametritis, chronic uterine fibrosis, and possibly uterine fibromas, are reasonably the results of an ascending lymphangitis extending upward from the cervix.

Cancer of the uterus is preceded by pregnancy in from 90 to 97% of cases, according to different authorities. Therefore, a very small percentage of cancer of the cervix occurs in women who have not borne children. In view of the almost inevitable trauma to the cervix in childbirth, and the consequent infection, it would seem reasonable to say that cervicitis bears a direct relationship to cancer. In a survey of cervix cancer patients treated at Cooper Hospital since 1920, we have found no case in which cautery or trachelorrhaphy had been done previously. Pemberton reported 5962 cases previously treated by cautery, amputation or trachelorrhaphy among which only 5 developed cancer, and these were trachelorrhaphy cases.

Bailey made the following summary: (1) The ultimate sequel to erosion of the cervix is cancer. (2) Cervicitis is definitely related to cancer. (3) The initial factor in cervical cancer is bacterial, and to a large degree concerns the organisms of sepsis. (4) Recurrent attacks of cervicitis during the dangerous years may result in production of cancer. (5) Cervical infection may be limited to the cervical glands without any other evidence of disease in the vaginal cervix. As Bloodgood has so often stated, if all cervical lacerations were repaired and disease in this organ eliminated, cancer of the cervix would become practically unknown. This fact cannot be too strongly emphasized.

Prophylaxis. Better obstetrics is the most important factor in prophylaxis. This we have certainly had during the past few years, but perhaps it is not always so complete as it might be. By *complete* obstetrics we mean care carried far enough into the puerperium to make sure the pelvic organs have been rendered as nearly normal and healthy as conditions permit. The following report by De Foe is enlightening. Studies of the cervical mucus from a midpoint in the canal were made from 500 pregnant women, prior to labor, during labor, and early in the puerperium; and streptococci were found: before labor, 1%+; during labor, 3%+; puerperium, 12%—.

Equally suggestive are Goodall's observations on puerperal morbidity in 500 labors. By injecting a mild antiseptic high into the vagina immediately after labor and continuing the same daily for 10 days, a very substantial improvement was noted in temperature and complications. The author's experience during the past 2 years, though limited, has very satisfactorily corroborated Goodall's conclusions.

When her child is 1 month old the mother should present herself for a complete pelvic examination, which should not be made at the patient's home but at the physician's office, where proper facilities are available. The cervix should be carefully examined for lacerations and infection. Slight erosion may be treated at once, preferably by the office cautery. Slight lacerations, in the absence of infection, may be ignored. Deep lacerations, with eversion, should be repaired by the unilateral trachelorrhaphy method as soon as the tissues are in condition. If the mucopurulent leukorrhea persists after a few months, in the absence of obvious cervical infection, an investigation of the cervical mucus should give valuable information.

Young children often suffer with leukorrhea which recurs at times and varies in amount during a period of years. More often than is commonly suspected the cervix is infected. The difficulty encountered, and patience required, too often result in neglect of these patients. In a small group of sterile women we have traced a history of leukorrhea far back into childhood. With an electrically lighted urethroscope, and a few whiffs of anesthetic, it is quite easy to observe whether pus issues from the cervical canal.

Summary

(1) Cervicitis is a very common disease.

(2) It is more common in children than commonly held.

(3) It is the chief cause of sterility, and the cause most amenable to treatment.

(4) The cervix is potentially infected in every case of labor or abortion.

(5) Cervicitis is important as a source of focal infection, so far as the pelvic organs are concerned.

(6) Leukorrhea should be regarded as indicating cervicitis until proved otherwise.

(7) The close relationship between cervicitis and cancer of the cervix should be kept ever in mind.

(8) Cervices in which chronic infections have been cured apparently do not develop cancer.

(9) In a certain measure prophylaxis in labor cases would appear possible.

DISCUSSION

Dr. P. Brooke Bland (Philadelphia): Of the manifold lesions found in the neck of the uterus, cervical laceration, especially when associated with infection, is by far the most frequent, and probably also the most serious. One may say that, potentially, cervical laceration with infection is the most dangerous condition found in obstetric and gynecologic pathology.

This question of cervical infection one might discuss from a great many angles. Dr. Lee, in his comprehensive presentation, has pointed out: (1) the causative relationship which the disorder bears to the symptom most frequently found in gynecologic practice, namely, leukorrhea; (2) he has

referred to the etiologic relationship of cervical infection to sterility; and (3) he has pointed out that the condition may have various forms of both local pelvic and constitutional disease.

Because Dr. Lee has dwelt on these various aspects of the topic, and because the next speaker, I assume, will discuss the problem from observations made in pregnancy and parturition, I shall limit my discussion of the disorder to its bearing on cervical cancer.

At the outset, one may become somewhat axiomatic and say that the most effective way to curtail or control the incidence of carcinoma of the cervix is to eliminate or overcome the factors primarily responsible for the disease; in other words, by eliminating the predisposing conditions of the disease it may, in a very large way, be overcome. We are all, I am quite certain, somewhat concerned about the growing menace of carcinoma, or cancer in general, and especially as it affects the organs of reproduction.

To me, it is somewhat upsetting to find that as a cause of death in women of the child-bearing age—from 15-44—it ranks second to tuberculosis. There is a worse feature when one compares the 2 conditions, because from year to year tuberculosis has shown a consistent and gratifying decline, while cancer has shown an alarming increase.

Of the different forms of malignant disease, with respect to its anatomic origin, cancer of the womb is regarded as one of the most deadly, and according to the last report of the Department of Commerce, Bureau of the Census, for the year 1929, 60,747 women died of malignant disease, and of this number 15,725 (25%) succumbed to cancer of the organs fundamentally concerned with propagation of the human species.

All of us, I assume, can recall that until a few years ago it was a most popular and rather intriguing custom to emphasize the early diagnosis of uterine cancer. This feature of the problem is no less important today, but, at the same time, it is only right to say that early symptoms and signs are rarely seen. Some observers go so far as to say that there are no early symptoms or signs of cancer, hence, save by good fortune or by accident, the disease is rarely observed in its early stage. It becomes obvious, therefore, that some recourse far more dependable than early diagnosis must be found and practiced. This, fortunately, is readily at hand. Figuratively, it dangles from the elbow of every practitioner, and is found in the prevention or prompt correction of conditions that may ultimately lead to the disease.

Dr. Lee has directed our attention to the frequency of obstetric injury of the cervix, in its relation to carcinoma, and, speaking as an obstetrician today, I have almost ceased to wonder why cancer of the womb is so frequent, but I do often wonder why all, or nearly all, women who have borne children do not develop cancer.

I have fallen into this rather pessimistic groove because: (1) of the frequency of lacerations of the cervix; and, (2) because of the callous indifference usually displayed with regard to treating conditions of this sort. Under no circumstances would a laceration or injury of similar extent be allowed to exist for a single hour on the surface of the body without receiving attention. It is probably because a cervical laceration is anatomically concealed that it is treated, as a rule, with such indifference.

Dr. Lee has pointed out that more than 90% of the women who develop malignant disease of the cervix have borne children and that the large majority have given birth to more than one child.

The frequency of the disease in parous women cannot be regarded as a coincidence. There must be an underlying cause, and it is generally believed that this resides in obstetric injury followed by tissue alteration incident thereto, and then by infection. This is the most definitely known lesion to precede cancer of the cervix. Obstetric damage, then, followed by infection and its sequel, irritation, expressed in endocervicitis, ectropion or eversion, must lead to tissue metaplasia with carcinogenic tendencies in a certain number of patients, and there is now substantial evidence, both experimental and clinical, strongly supporting this view. One investigator, for example, found in almost every instance a malignant process developing on the edges of a fibrosed sore or on a frankly ulcerated surface.

Dr. James E. Davis, of Detroit, from a systematic study of more than 3500 microscopic sections prepared from 1200 cervical biopsies, found abundant convincing evidence of what he regarded as the essentials of pre-malignant and malignant disease.

So much, then, in brief, for the experimental evidence in support of obstetric damage with its sequel, prolonged and unremitting irritation, as a cause of cervical cancer. Aside from this feature of the study, the clinical aspect, as pointed out by Lee, also provides proof of the causative rôle played by obstetric trauma, especially from the standpoint of therapeutics.

In a series of something more than 12,000 cases of cervical damage treated by either repair or cauterization, or excision by the electrothermic knife, or by trachelorrhaphy or repair, fewer than 10 patients developed carcinoma of the cervix subsequently.

Finally, may I say that it is my belief that cervical damage is exceedingly uncommon following a straight-forward normal labor. Gross injury is the result, usually, of unwise or unskilled manual or instrumental delivery. The former practice of routinely submitting all patients to vaginal examination during labor, with the irresistible impulse to aid the patient manually by dilating or stretching digitally the attenuated cervix over the presenting part was unquestionably responsible for a great deal of cervical damage with its great train of complications. One can scarcely guess how much this unnatural practice has cost in morbidity, both immediate and remote. One may assume, therefore, that solution of the cervical cancer problem, so far as prevention is concerned, rests almost squarely on the shoulders of those who practice obstetrics. In the past, I am afraid that they have fallen somewhat short in that respect.

Dr. J. Ward Montgomery (Philadelphia): This subject has been so excellently and so completely dealt with in Dr. Lee's paper and in Dr. Bland's discussion that little remains to be added.

It has been shown that the cervix stands pre-eminent among the sources of focal infection in women. While it is a disputed question—whether or not disease of the cervix can produce disease in remote parts of the body, notably arthritis and other rheumatic conditions—there is no disputing but that it is the starting point of extensive pathology in the pelvis and an obvious fore-runner of malignant degeneration. The cervix, therefore, occupies a position of far greater pathogenicity than the diseased tonsil.

As obstetricians, we are particularly interested in the effect that disease of the cervix has upon the condition of mother and child during labor and during the puerperium. Here, disease of the cervix acts as a focus from which inflammation extends to the uterus and the peritoneal cavity. During pregnancy and early labor, the unruptured membranes act, apparently, as a barrier to the extension of inflammation. As soon as the membranes rupture, bacteria enters the uterine cavity. The extent and virulence of the resulting infection of the endometrium depend upon the resistance of the patient and the character of the invading organisms. This type of "autogenic" infection is now well recognized.

Perhaps we are less familiar with the effect which cervical infection may have upon the fetus and the secundines. We have paid particular attention to this problem in recent studies in the Department of Obstetrics of Jefferson Medical College Hospital. I have with me a few slides which serve to illustrate the progress of inflammation from the cervix along the membranes to the margin of the placenta, and through the placental veins and umbilical vessels to the fetus. (Lantern exhibition of slides followed.)

The question naturally arises—How can this complication be avoided? There are 3 methods to be considered: (1) The obstetrician should not discharge his patient after delivery until the cervix is perfectly healed and continuity of the mucous membranes restored. The eroded cervix is best treated by topical application and cauterization. (2) Every woman who has borne a child should have an annual health examination; which should include careful inspection of those parts which have been concerned in childbirth. If the cervix is found to be diseased, it should then be treated until returned to a healthy condition. (3) If a gravid patient presents a diseased cervix, an endeavor should be made to alleviate the local inflammation by the use of appropriate douches carefully administered, and by the local application of mild antiseptics.

There is a rather general hesitancy on the part of physicians to treat the cervix during pregnancy. I can only say that in the series of patients which we have treated in this fashion, the puerperal morbidity was less than that of the general ward morbidity; and in this same series miscarriage or premature labor occurred no more frequently than it did among the other ward patients.

TREATMENT OF ECLAMPSIA

S. A. Cosgrove, M.D., F.A.C.S.,

Chief of Obstetric Service, Jersey City Medical Center and Margaret Hague Maternity Hospital,

Jersey City, N. J.

To be asked to talk about the treatment of eclampsia is to be required to discuss treatment of a condition which no one has clearly defined; of which none knows the etiology; which has no absolutely specific pathology; and, the manifestations of which are so protean and confusing as to defy a wholly satisfactory classification.

Convulsions and coma accompanying pregnancy, parturition and the puerperium, have been known from the earliest times of recorded medical history. Although only symptoms, their occurrence in connection with pregnancy has been, even up to the present time, recognized as constituting a more or less definite entity just as in the past other symptoms, such as jaundice, and what were believed to be special types of fever, were recognized as entities. Until about the beginning of the present century they were most frequently written of and discussed under the terms "convulsions of pregnancy" or "puerperal convulsions".

The term *eclampsia* is of Greek derivation, meaning—to flash out—and, from its derivation, is applicable to any type of convulsion, and is in fact so defined in current dictionaries. It is, thus, just as proper to speak of "infantile eclampsia"—referring to the spasmophilia of infancy—as it is to speak of "puerperal eclampsia" with reference to the convulsions occurring in pregnant and puerperal women. But, about a century ago, use of the term in this latter restricted sense came into vogue, and it has advanced until today it is almost universally understood to have this significance.

This usage is, however, just as unsatisfactory from the clinical as from the etymologic standpoint, because convulsions may occur in the pregnant or puerperal individual, depending on all the varied causes of such convulsions in the non-pregnant female. Moreover, cases occur in pregnant women and puerpera, without convulsions, which are otherwise indistinguishable, in their clinical course and pathology, from those exhibiting this particular symptom. This latter fact necessitates broadening the term of what is ordinarily understood by eclampsia, to include others of the so-called toxemias of late pregnancy. Thus, that condition generally referred to as pre-eclampsia *is* eclampsia, except that convulsions have not developed. Any other view is as absurd as to say that typhoid fever *without*

perforation is different from typhoid fever *with* perforation!

From the time of its earliest recognition, until about the middle of the last century, the most striking symptoms of this condition—the convulsions and coma—caused eclampsia to be more or less identified with other well known conditions associated with similar symptoms, so that it was classified as depending on apoplexy, epilepsy and hysteria.

Discovery of the means of detecting albumin in the urine, the classical work of Bright in relation to the nephritides, and observation of the frequency with which the state under discussion was associated with albuminuria, led to its being identified with nephritis. But the fallacy of this was early noted, in that many patients with pregnancy-albuminuria did not develop convulsions, whereas convulsions did occur in pregnancy at times without the prior appearance of albuminuria.

There gradually developed, from the fact that both symptoms and pathology more or less simulated the results of other known poisons, the concept that this syndrome must depend on some poison in the victim's body; and, inasmuch as the supposed poison affected all organs and systems of organs, that it was probably one which circulated in the blood. This gave rise to the term *toxemia,* which is today universally used, under the highest authority, in spite of the fact that the existence of such a poison has never been definitely proved, nor its identity determined.

Derived from this concept of a circulating poison, many varied ideas have been promulgated, as to the probable identity of this hypothetic agent, and from it has arisen the impetus for a tremendous amount of frantic search for such an agent. Space will not permit a review of even the more plausible of such suppositions. Each in turn has been enthusiastically put forth, but has not been able to withstand the discrepancies which clinical and pathologic facts arrayed in opposition.

The battle of hypotheses continues, some of them which have from time to time been most widely accepted still holding their adherents. Thus, Stieglitz only very recently discussed these morbid states as nephritides, while Duncan based his whole discussion of their nature and treatment on the slogan: "There is but one toxemia of pregnancy." Conflicts as to the fact and significance of chemical findings in urine, blood and tissues, are sustained and bitter, and one does not feel, in reviewing them, that any conclusions can as yet be accepted. One individual's guess, as to the nature of these morbid states, is as valid as another's. The evidence will not permit, even today, a clear conclusion as to whether the symptom-complexes of the allegedly toxic disturbances of pregnancy constitute the widely varying manifestations of one cause, in the same sense that tremendously different clinical pictures may depend on infection with such a specific agent as the typhoid bacillus, or whether more or less similar symptom-complexes occur in pregnancy, depending on a variety of disturbing factors in the same way that other general symptoms, such as fever and anemia, may depend on any one of a large number of causative conditions. Even the sure dependence of some authors on supposedly characteristic liver pathology, in differentiating this whole group of disturbances into several essentially dissimilar processes, is hardly valid, for Acosti-Sison has shown, in a carefully studied series of autopsies on typical eclamptics, a variation in the nature and location of liver lesions which would appear to throw such painstakingly systematized conclusions into new chaos.

One may, therefore, say only in the broadest general terms, that certain individuals, because of inherent constitutional defects and/or acquired visceral or systemic damage, sometimes too occult in nature or degree to be recognized in the non-pregnant state, exhibit an intolerance to pregnancy characterized by widely variant pathology, in nature and degree; affecting any or all of the important parenchymatous organs and systems; manifesting itself by many different forms and combinations of clinical effects, some of which may be essentially different, but all of which are more probably fundamentally related; that each such clinical form may be of so serious a degree as to dangerously threaten life; that one or several such forms which happen to

be attended by specific symptoms, namely, convulsions and coma, are rather illogically designated as a specific entity by a wholly non-specific term, eclampsia; that the ultimate cause and pathogenesis of all these disturbances is unknown.

Just as, in spite of a tremendous amount of thoughtful and intensive study of every phase of this condition, little headway has been made in the solution of an ultimate etiology; so, little real change in underlying possibilities of treatment has been made during a period of almost a century. Without the guidance of such knowledge of etiology, treatment has necessarily been partly predicated upon the particular theory thereof currently in vogue, but in the main has been wholly empiric in its direction toward the alleviation of symptoms. Two important exceptions appear, to me, to exist to this general statement regarding lack of advancement in therapy: (1) the importance which has come to be laid on prophylaxis and early recognition of premonitory hints of the development of these morbidities; (2) the general simplification of the schemes for curative treatment.

Up to the middle of the last century there was little recognition of early or prodromal symptoms, and of the fact that certain definite types of pregnancy disturbance were prone to lead, if unchecked by treatment, to the dramatic explosion which instantly commands every resource of treatment. Hence, there was scarcely mention, at this time, of any prophylactic treatment.

But, by another generation, there was quickened appreciation of "forewarning symptoms" which, if detected by careful watchfulness, might enable the attendant to institute treatment early enough to ward off the ultimate disaster. Thus the warning of Barnes, 50 years ago—that "nothing short of a systematic and frequently repeated examination of the patient throughout pregnancy can avail" to avert catastrophe—can hardly be improved upon in fact or phrasing, today.

Before dwelling upon the simplicity of modern regimens of treatment and pointing out how this constitutes advancement, it will be well to discuss certain specific details which have from time to time been employed, and see why they have survived, as parts of modern treatment, or fallen into disuse.

Early treatments were wholly predicated on the conception of a nervous crisis *per se,* and so represented a translation of the standard treatments for other explosive, nervous crises, together with termination of the pregnancy, which was regarded as directly causal. Inasmuch as this latter consideration must, even today, be regarded as broadly, but perhaps less directly, true, and inasmuch as measures generally directed toward an eliminative or detoxicating regimen were included in the symptomatic treatment scheme, it will be noted that these early treatments embraced:

I—Control of symptoms.

II—Elimination or detoxication.

III—Modification of the persistence of pregnancy.

Except as we today apply them more intensively as prophylaxis, and continue them after subsidence of the acute phase against recurrence in subsequent pregnancies, these lines of therapeutic endeavor comprise our own objectives.

I—Control of Symptoms

(1) *Quietude,* obtained by segregation, expert, quietly efficient attendance, exclusion of light, plugging the ears, avoidance of unnecessarily disturbing examinations and manipulation, was recognized as essential by the earliest observers. It still holds a deservedly important place in management.

(2) *Posture.* One early suggestion was use of the upright posture to lessen by gravity the intracranial pressure. Modern authorities do not stress this, but it is of peculiar interest by reason of comparatively recent animal experimentation which indicates that changes in physiologic and pathologic intracranial pressure can actually be so modified, and the proposal to make therapeutic use of this fact in new-borns suspected or known to be suffering from increased intracranial pressure. On the other hand, the importance of the inverted posture to promote bronchial drainage for patients in coma or exhibiting pulmonary edema, is stressed by numerous authorities at the present time.

(3) *Restraint* and protection of the violently disturbed patient from self-injury, have always been obviously necessary. False teeth should be removed from the mouth. An anesthetist's pharyngeal breathing tube protects the tongue from injury, permits easy cleansing of mucus from the pharynx, and early re-establishment of the airway as convulsions subside. Attendants must be instructed to limit their restraint to prevention of injury, as the too-zealous attempt to restrain muscular restlessness often adds to the excitation of the patient, whose struggles against it may even precipitate convulsion.

(4) *Opiates.* The utility and dangers of opium (and its derivatives) have formed one of the minor foci of controversy at all times. Ramsbotham strenuously objected to them on the ground that pharmacologically they are "stimulants", a view rather strange to our own conceptions, but they have held a sure place in nearly all plans of therapy, though principal discussion has been as to the intensity of dosage. Some authorities have not hesitated to exhibit them to the limit of tolerance. The majority, however, used them with more caution, having in mind the depression of the respiratory center depending on them, the resultant increased tendency to pulmonary complications to which these patients are peculiarly susceptible, and the danger of asphyxiating the fetus. Yet, while this attitude of cautious moderation in dosage characterizes majority opinion today, Beck still advocates heroic dosage to the point of maximum respiratory rate depression. Our own tendency is to avoid such extreme dosage, preferring to rely, for convulsion-control, on combinations of relatively small doses of morphine, with other agents.

(5) *Chloroform.* Almost immediately following its discovery, this easily handled anesthetic was seized upon as most valuable in the treatment of eclampsia, and for years estimates of its usefulness were not less than panegyric, and various noteworthy reductions in mortality were credited to it. Cragin first emphatically challenged its claims, pointing out that liver pathology closely analagous to that of eclampsia was caused by its use even in therapeutic dosage. This was confirmed by Williams and his co-workers, who later attributed similar dangerous propensities to all inhalation anesthetics. While Stroganoff still includes it in his "treatment", which has inspired many of the prevalent methods of handling this disease, chloroform has dropped out of use entirely in nearly all important American clinics. We, ourselves, do not use it at all.

(6) *Veratrum viride* for a considerable period, embracing the beginning years of the present century, enjoyed a vogue as an almost specific drug, but its danger as a circulatory depressant, on the one hand, and its comparative inefficiency in comparison with other agents, on the other, have caused its use to be abandoned in large clinics, though it has by no means wholly disappeared from community practice in some sections of the country.

(7) *Chloral.* In spite of its chemical relation to chloroform, now under ban, chloral obtained for itself a favored place soon after its introduction, which it has retained, being embraced in nearly all of the "conservative" plans of treatment.

(8) *Bromides* have long held, and continue to hold, a secondary place in many schemes of treatment, though in a few clinics they are chiefly depended on for sedative action.

(9) *The barbiturates* have been used in many clinics, of recent years, especially abroad, and it is conceivable that they may have usefulness, but opinion in this country does not yet seem to be strongly crystallized in their favor. Our own experience with them is too meager to justify an opinion.

(10) *Magnesium sulphate.* Lazard and Dorsett depend practically entirely on intravenous injections of this drug in repeated doses of 2 gm. each, in 10% solution. While it is still used in many clinics, it must be acknowledged that the literature does not reflect upon it a universal enthusiasm. Immediately after the originators' first publication, I treated a patient strictly according to the described technic, without any other treatment, with good results: Symptoms were quickly controlled; a few days later the patient deliv-

ered a healthy baby; and she progressed to smooth and complete convalescence. Since that time, this method has been a component of our standard treatment. It is efficacious in controlling symptoms, reduces the quantity of morphine necessary for this purpose, and has caused no unpleasant results. We have had no comparatively high mortality from its use, as has Irving.

(11) *Nitrates* in various forms have, naturally, suggested themsevles as useful in directly lowering blood pressure, but their value has not proved sufficient for retention.

(12) *Lumbar puncture* has been extensively, and cisterna puncture less frequently, used to reduced the supposedly increased cerebrospinal fluid pressure. We have not felt that we know enough about actual conditions to warrant using this procedure, but observations are now being made on our service in an effort to obtain data concerning this matter.

(13) *Local depletion* to the head, effected by measures such as shaving the scalp, use of cups, leeches and blisters locally, is obsolescent, of course, although the application of cold to the head and neck is used occasionally.

(14) *Venesection.* Placed last in the group of resources designed to control symptoms, because of its possible conception as also belonging to the next group of detoxicating methods, venesection constitutes another focus of much controversy. Originally applied, probably, because of its status at the time as a remedy meeting almost any indication, it somewhat later came to be universally hailed as the most important of all remedial measures. In the older days large quantities of blood, up to almost 2 litres, were repeatedly abstracted. Ramsbotham quotes Gooch as saying: "All the women who died * * * had been bled insufficiently." (!) Beck, even today, advocates copious venesection, with large doses of morphine, as comprising all the treatment necessary. But, the considerations—that many of these patients are already anemic; that usually they do not stand excessive blood loss well; that if undelivered, the blood loss incident to subsequent delivery cannot be calculated beforehand, and may prove serious when superadded to that lost by venesection; that the change in blood pressure and other symptoms induced by venesection is not more than briefly transient in the more serious types of cases—led early in the present century to greater moderation. Few authors but concede that it has occasional usefulness, and it has been suggested that much of the benefit so often seen following delivery is in reality due to the blood loss dependent upon it. Present opinion, however, is generally conservative and venesection is restricted in most places, as it is on our own service, to amounts not in excess of 500-800 c.c., and to employment only rarely, and then in especially fulminant conditions in sthenic individuals.

A variant of venesection, perhaps as useful and less objectionable, is plasmaphaëresis, in which the plasma of withdrawn blood is separated from the cells, by *centrifugation,* and the cells then washed repeatedly in saline solution, diluted up to the original volume in the same solution and re-injected. Irving is enthusiastic about it. We have no experience on which to estimate its value.

Blood transfusion does not appear to meet very specific indication, though we have used it following venesection, and after the subsidence of acute symptoms in the presence of definite anemia.

We have not used normal or convalescent human serum.

II Eliminative and Detoxicant Measures

(1) *Diet.* The more or less definite feeling that eclampsia depends on metabolic disturbance, and that restriction of diet minimizes the metabolic burden to which the pregnancy is an unsupportable addition in the affected individual; and the several theories which from time to time have assigned intermediate or end products of protein metabolism, as the specific toxins of the disease; the later ideas of the importance of salt in governing the osmotic balance between blood serum and tissues, disturbance of which results in the tissue water-retention so commonly manifested in the edema accompanying the disease; and, finally, the idea of hypoglycemia depending on insufficient carbohydrate intake; have all contributed to general restriction of diet, to the special restriction of proteins, to the elimina-

tion of salts therefrom, and to stress upon the importance of the carbohydrate component. All of these tendencies continue to influence ideas of diet, but there is less importance assigned today than formerly to the proteins.

Water has been generally held to be an eliminant and diluent of supposed toxins, and its administration has been advised by most teachers. Arnold, of Philadelphia, adopting the suggestion of Temple Fay, that restriction of water lessens cerebral edema, has recently advised keeping the amount of water ingested, or otherwise administered, to a level below that of the renal output. Dieckman, on the other hand, insists that the blood in eclampsia is pathologically concentrated, and that it is not only necessary to introduce water in a competent amount into the circulation, but in some cases to use glucose or acacia to keep it there.

(2) *Gastro-enteric elimination.* Efforts to enhance these processes have always been to the fore. Early use of emetics has given way to that of lavage, which is one of the cardinal points in the "Dublin treatment" in use at the Rotunda Hospital in that city. Former free use of drastic vegetable and mineral purgatives has largely been abandoned, though magnesium sulphate continues in some favor; largely superseded by enemas and high colonic irrigations. In general, all these measures have been relegated to a place of less importance, because they were productive of so much disturbance of the patient.

(3) The last consideration, together with waning faith in their real utility, accounts for the greatly lessened importance of measures to promote elimination through the skin. These formerly embraced use of drug diaphoretics like jaborandi and pilocarpin. Such agents are no longer used but are, rather, considered contraindicated because of their producing depression. Wet or dry hot packs, in many forms, were very generally used in the past, but now much less frequently. They still remain part of the scheme of treatment in some places, however, as in Bill's Clinic, in Cleveland.

(4) The same general statements may be made as to specifically direct diuretic drugs. It is probably true, however, that various hypertonic solutions, such as those of magnesium sulphate and glucose, sometimes used for other supposed direct effect, do actually tend to increase renal elimination; and may even owe their apparent clinical value to such action.

(5) Oxygen has been used to aid pulmonic elimination, and Edgar regarded it highly. As it has been so often used as a routine resource in the presence of actual pulmonary complications, its value as a factor in elimination, or efficiency of metabolic processes, is hard to evaluate.

(6) Certain radical, surgical procedures designed to detoxicate, such as amputation of the breasts or decapsulation of a kidney, are so obviously undesirable as to deserve mention only as historical incidents.

(7) Two measures may be considered among the detoxicating devices, inasmuch as they are designed to correct deficiencies upon which intoxication is supposed to depend. The first is glucose, now extensively used under the impetus of the theories of Thalhimer and Titus relating to hypoglycemia and glycogen depletion. While apparently valuable clinically, that does not prove the theories in question, as such value may depend on the fact that its solutions supply water to the circulation, and to some extent tend to retain it there; that it appears to be powerfully diuretic; that it may help to restore normal osmotic balance between blood serum and tissues; and that it represents easily available nutriment of high caloric equivalent.

The second is heparmone, an extract from animal livers, the administration of which is believed by Miller and other workers to protect the liver from the degenerative effects of the hypothetic toxic agent, and enhance its functional activity. The majority of observers have not been able to confirm its success in these directions, and we have had no experience with it.

III Modification of the Persistence of Pregnancy

In discussing this phase of treatment we deal with the subject of the most sanguinary controversial battle concerned with eclampsia.

It is a disease of pregnancy. Eliminate the pregnancy and the disease is controlled. This would appear the clearest common sense reasoning, and the universal observation of clinical improvement when the fetus dies or is extruded, gives confirmation.

Early workers strove, therefore, to expedite delivery by forceps, version or craniotomy. As anesthesia was introduced and asepsis merited greater boldness, this effort looked to earlier interference, and the rapid artificial dilation of the cervix and extraction of the fetus were practiced. Multiple trachelotomy, "vaginal cesarean section" and abdominal section were added to our surgical resources.

A half century ago, Barker said that the earlier teaching was "to deliver by any means in our power as speedily as possible". He, however, condemned "injudicious measures to terminate the labor" and specified that only "whenever delivery by art can be effected by less irritation than would be produced by continuance of the child in the parturient canal, should it be resorted to." But, in spite of this clear statement of sound practice, 30 years later toxic patients were smothered with prolonged anesthesia, every canon of good obstetrics was violated, laparotomy was blithely undertaken in patients who would have been considered the poorest risks for any other major procedure, and mortality did *not* diminish!

When Stroganoff, about this time, brought forward his series of patients conservatively treated, with a mortality which put to shame other results general at the time, he was greeted with a more or less scientific equivalent of the well-known "raspberry"—and the tearing and pulling and slashing went on. He reappeared with larger and more arresting statistics a few years later, and at last the significance of his work made an impression, and all the tug-and-rip boys did a prompt about-face, and since then there has been a marked swing away from radicalism. Almost the whole obstetric world is now marching in step with "conservative" practice. Yet, it is not unamusing to note what fervent sighs of relief go up from the most confirmed conservatives when the fetus dies in utero, or how eagerly they seize the opportunity to terminate the labor as soon as nature has almost done it for them!

A few people have been out of step with this steady march toward conservatism. Peterson has persisted in representing the good results of judicious radicalism. I am told that in Vienna there is again a tendency to resort more frequently to cesarean section; Williams and others concede that in a very few fulminant cases expediting delivery, even by resort to section, may be necessary. Our own feeling is that termination of pregnancy is ideally desirable if and when it can be accomplished without adding to the maternal risk. It cannot be so accomplished, however, if it entails prolonged general anesthesia, laceration of soft parts, shock, or the adoption of section or any other particular procedure in the presence of conditions which would under other circumstances make them contraindicated.

The determination of particular procedure outlines as superior to others must depend largely on comparative results in the same clinic. At any given period, statistics from a number of sources are so conflicting, and present so many unreconcilable discrepancies, as to be very confusing. While a certain amount of guidance may be obtained from summing up opinions of the majority, or of those whom the investigator believes best qualified and balanced, one's own immediate results are necessarily his most accurate guide. Our own experience has followed the general trends of practice sketched.

Prior to 1920, morphine was pushed to the limit by physiologic tolerance; veratrum veride was regularly exhibited; gastric lavage was followed by croton oil or magnesium sulphate was left in the stomach; immediate active interference was practiced, including, frequently, resort to abdominal section; wet, and later, dry hot packs were used; high colonic irrigations were frequently given; phlebotomy was sometimes employed; an alkalinized gelatine solution was used intravenously; ether, gas and local infiltration with novocaine were the anesthetics.

During the period 1920-1925, we continued

early emptying of the uterus; morphine was used more moderately, augmented by chloral, bromides or paraldehyde; veratrum had dropped from use, as had the drastic purgatives. Intravenous solution of magnesium sulphate and weak solutions of glucose were in use; phlebotomy, when done, was followed by blood transfusion. Inhalation anesthesia was almost entirely abandoned.

We believe that our results in this second period were superior to those in the first but, unfortunately, accurate statistics are hard to compile. As nearly as we could estimate at the time, however, our maternal mortality was about 16%, which was not bad in consideration of the fact that many of our patients were admitted late in their course, pre-natal clinics not being organized on so complete a scale as they were later.

A third period embraced the 3 years, 1926, 1927 and 1928, during which essentially the same combination of medical treatment with active interference was followed.

In the fourth period of 3 years, 1929, 1930 and 1931, our practice has been wholly conservative, no surgical procedure other than occasional low forceps extraction being done for the eclampsia *per se,* though 1 section was done for mechanical indication during intrapartum eclampsia.

In greater detail, our present treatment is as follows:

Prophylactic treatment includes the entire régime of antenatal care. While recent surveys have shown that extension of such a régime in New York City has not resulted in lowering total maternal mortality as much as had been hoped, there is no doubt that the incidence of fulminant degrees of pregnancy toxemia has been lowered in proportion to such extension. The lessening of total mortality from these conditions depends more importantly on this development than on any form or modification of the treatment of their actual fulminance. Our complete régime embodies:

(1) Frequent close observation of all pregnant women from the earliest time possible.

In this connection, history, blood pressure, urinalysis, weight and general signs and symptoms, should be noted; all are important, but detailed attention to the last named is perhaps most so. The recent work of Bingham, in dietary regulation and systematic exercise anticipating actual appearance of abnormality is, we think, highly important. We shall not take time to dwell on the other familiar details of pregnancy hygiene.

If abnormalities indicative of toxemia develop, the régime must be intensified by rest varying from minimal restriction of activity to hospitalization and bed-rest. Diet must be more restricted, especially as to the elimination of salt. Observation must be augmented by more detailed and frequent urinalysis, renal and hepatic function tests, blood chemistry observations, records of intake and output, and enhancement of elimination by mild catharsis and high colonic irrigations. In our experience drug therapy is not important at this stage.

Failure to improve in a reasonably short time should lead to considering the termination of pregnancy, the means adopted depending on age, parity, previous pregnancy and labor history, viability of child, social, religious, and personal considerations peculiar to the individual patient, the severity of the condition, the presence of special symptoms, and the estimated imminence of impending disaster.

If the patient develops, or is first seen with, an actual state of eclampsia, our regular régime of treatment, modified in some cases by special conditions, is instituted. It consists of:

(1) Segregation of patient.

(2) Darkening of room and every inducement to quiet, unpanicky attendance.

(3) Provision to guard against self-injury.

(4) Intravenously, 20 c.c. 10% solution magnesium sulphate, repeated at 1 hour intervals so long as convulsions persist; as they subside, dosage is cut down progressively to 8 and 12 hour intervals; continued at the last rate for at least 24 hours after convulsions have stopped.

(5) Morphine sulphate, gr. ¼ by hypo. is given at the beginning of treatment and

usually not repeated; if severe, morphine and chloral may be alternated as in the Stroganoff treatment.

(6) Intravenously, 300 c.c., 25% glucose solution, repeated at intervals of 4 to 12 hours; important not to exceed a rate of 4 c.c. per minute in administration.

(7) High colonic irrigations of 5% sodium bicarbonate solution are given every 12 hours.

(8) Drainage and aspiration of tracheal mucus practiced when necessary.

(9) Venesection is only rarely used, in threatened right heart failure.

(10) Fluids of high carbohydrate content are permitted as soon as patient can swallow; later augmented by a more general low-protein, salt-free, high carbohydrate diet.

our present standard procedure. All manipulations requiring anesthesia are done under subdural injection of novocaine.

Statistics for the last 2 periods indicated above, together with those of a small private series, arranged for comparison, show the following:

It will be noted that the only essential difference between the scheme of treatment in these 2 periods, the results of which are analyzed, was the almost complete elimination of the more radical type of surgical interference; in other words, the dependence almost wholly on medical treatment. The reduction of maternal mortality as between those 2 series by 52%, and the reduction in the gross fetal mortality by almost 30%, are so striking as to

	Public Series— 1926-27-28	Public Series— 1929-30-31	Private Series— 1909-32
Cases	3320	4865	4415
Eclampsia	45	47	28 (29 babies)
Incidence	1:74	1:103	1:156
Cesarean section	9	1	8 (1 death)
Vaginal cesarean	0	0	4
Forceps	12	14	8 (1 death)
Version	2	1 (postmortem)	1
Breech extraction	1	0	0
Inductions by bag	3	0	6
Catheter			1
Maternal mortality, %	17.7	8.5 (correction by elimination of 2 cases dying within one hour of admission gives 4.3%)	7.1
Fetal mortality, %	44.3	31.7	20.6
Still-births, %	34.	18.8	10.3
Neo-natal deaths, %	10.3	12.9	10.3

If the patient recovers undelivered, and the child is viable, we believe that she should be delivered within 48 hours as described under prophylaxis. While some of our patients have gone on to delivery at full term, we believe that the risk of a second, more disastrous fulmination is too great to permit this except in special instances.

If the patient goes into labor and does not progress very rapidly to the finish, we expedite the second stage by low forceps extraction.

If the patient exhibits great and unremitting fulminance, without labor commencing, pregnancy should be terminated promptly by rapid cesarean section. This indication is exceedingly rare, however, and is a departure from

need little comment. They forcibly exhibit the superiority of the wholly conservative treatment over even a judicially applied radical method.

The smaller series of private patients represents also the application of a more radical component in treatment and would appear to contradict the comparison between the other 2 series, by reason of the excellence of the results shown, in that the gross maternal mortality is less than that of the conservative series. Closer inspection, however, will reveal that this mortality is not so favorable as the corrected maternal mortality of the conservative series. Moreover, it indicates that the mortality in those subjected to cesarean section amounts to 12½%, much higher than

the general average in the series. On the other hand, the fetal mortality is less than that in either of the public series. Too much stress cannot be laid on this fact, however, inasmuch as the series is smaller, and the difference in social status of the patients in this series, as compared to those in the public series, may be a factor in the statistical difference, especially as the analysis does not indicate the relative proportion of the chronic nephritic type of toxemia, which one might assume to be higher in the public series. Nevertheless, it is probable that the institution of prompt evacuation of the uterus, on the appearance of fulminant symptoms, may save babies that would be otherwise sacrificed. This fact may, by reason of the value placed on fetal life under some individual circumstances, justify the acceptance of a slightly higher maternal risk. That this is occasionally true does not affect the general conclusion to be drawn from this table, that the wholly conservative treatment of eclampsia is better than the most carefully applied radicalism on the basis of comparative mortality results.

Conclusions

(1) The etiology and nature of eclampsia are unknown; its pathology is varied and in the main, non-characteristic; its classification is obscure and unsatisfactory; because of these facts its treatment has been, and remains, largely symptomatic.

(2) Historically, its treatment has traversed a cycle from moderate radicalism, as pertains to surgical intervention, through a phase of more violent radicalism, and has returned to a status of almost complete conservatism.

(3) Its present status embraces:

(a) Prophylaxis, its most important phase; here radicalism, to the extent of unhesitating interruption of pregnancy, when necessary, holds a legitimate and important place.

(b) Control of symptoms.

(c) "Detoxication" by elimination.

(d) Modification of the persistence of pregnancy. This phase is now practically wholly eliminated in favor of increased stress laid on b and c.

(4) The conclusion as to the superiority of the conservative over the radical method, is strongly indicated by results in 120 cases of eclampsia occurring in 12,591 deliveries.

Note.—Grateful acknowledgment is made to Joseph Binder, M.D., Attending Obstetrician to the Margaret Hague Maternity Hospital, for the use of material collected by him, with reference to the public series, at that institution.

DISCUSSION

Dr. James F. Norton (Jersey City): Dr. Cosgrove has presented, in the scope of a relatively short paper, all that anyone could wish to hear who leans at all toward the conservative method of the handling of eclamptics. He has stressed the point that there is nothing known of any definiteness concerning the etiology of this condition and has referred to the inadequate and rather cumbersome classifications that have been offered. Denied a definite etiologic factor, it is apparent that treatment cannot be easily handled, and it offers us also a ready field for divergence of opinions.

Those of us who are committed to more radical methods of handling these patients can, I am sure, offer statistics that will in many instances compare favorably with those presented by Dr. Cosgrove. However, I think that in the promulgation of particular form of treatment, it should be one which is safe for use by the man who is not committed to obstetrics as a specialty, and one to which we should most heartily subscribe.

The conservative method of handling eclamptics today, as Dr. Cosgrove has pointed out, is one which means not only treatment after they have had a seizure, but is one that, with discrimination, may be used in many instances before they reach the point of threatened seizure. I have had no personal experience with the radical method of handling eclamptics. Some people claim that the greatest field, and no doubt the claim is justified, the most marked, fruitful field, for improvement in the care of eclamptics, lies in the field of prophylaxis; some claiming that in private practice, where they are able to follow the patient from the early months of pregnancy on to delivery, they have had no eclamptic seizure. They are extremely fortunate, and must have far better control over their patients than many of us enjoy.

As to the group Dr. Cosgrove reported from general service, many of them, had they been private patients, could probably have been protected from seizures.

In the hospital with which Dr. Cosgrove is identified, these patients are regarded as suffering from a pregnancy complication, and we try, as best we can, to improve their general condition, so that if they need have any major obstetric operations, such as version, forceps, or cesarean section, they will be in as good general condition as possible before surgical measures are required.

Dr. S. G. Berkow (Perth Amboy): Having observed the ease with which radiologists terminate early pregnancy by x-raying the ovaries, and the almost total lack of morbidity of those patients, it occurs to me that if the same procedure will yield as good a result in the later months of pregnancy, that might be an almost ideal method of emptying the uterus in cases of eclampsia. A radiologist to whom I spoke of this assured me there was a possibility of such a good result. I have not had occasion to try it out, but I have it in mind to try at the next opportunity. It is, of course, not unlikely that the same thought has occurred to others and I should like to have Dr. Cosgrove's opinion of such a procedure.

Dr. P. Brooke Bland (Philadelphia): I was very deeply impressed by Dr. Cosgrove's presentation. He expressed my ideas precisely with regard to care of the eclamptic patient; the plan of therapy he outlined, pre-natally and during the eclamptic seizure, is along the lines we practice in our clinic. Many years ago, with a great deal of reluctance, I gave up radical therapy for these patients, but after crossing the Rubicon, so to speak, I could not possibly be persuaded to retrace my steps. I think that I am, if anything, a bit more conservative than Dr. Cosgrove.

He has quite rightly pointed out the futility of instituting major surgery on patients suffering with such a grave condition as eclampsia. No one would ever think of operating for any intraäbdominal conditions with a patient cyanotic, the heart on the brink of failure, so why ever think of doing a cesarean section during an eclamptic seizure? I couldn't bring myself to follow such a course. We abandoned it long ago.

We go, as I said, just a little bit farther in our conservatism than Dr. Cosgrove and even after 48 hours we wouldn't think, if a patient responded to our conservative plan, of instituting surgery, because we feel that if the convulsions subside and the condition of the patient is improved, we can postpone intervention indefinitely, and we do, we allow them then to go on and deliver themselves spontaneously.

Dr. S. A. Cosgrove (Jersey City): I should like very much to thank those who discussed what I have tried to say. Dr. Norton, of course, I expected concurrence from, because we meet so frequently in Hospital Board meetings where we thresh out these questions, back and forth so often among ourselves that I knew what I was saying here pretty well constituted the concurrence of opinion among our own staff.

Dr. Berkow's suggestion of using x-rays to terminate pregnancy in the toxemias is one we certainly have not undertaken, that we have hardly entertained in thought even. It is inconceivable to me, in my present state of what may be considerable ignorance, that it could be safely undertaken with respect to the fetus. Inasmuch as most of these toxemias occur in the last trimester of pregnancy, and in most of them the fetus, if it survives at all, is in a viable stage, and also inasmuch as we have just as direct and heavy a responsibility toward the fetal life as we have toward the maternal life; I would very much hesitate to even tentatively employ such a measure of terminating pregnancy.

Dr. Bland's remarks have been most kind. I put a tentative period of 48 hours on the interval following convulsion, at which I thought intervention might be in most cases justified. In 23 years of private practice and 5 years of public service experience, I have seen only 120 cases of eclampsia. That represents considerable obstetric material, and yet 120 cases is so insignificant a number as compared with the tremendous numbers of cases that individual observers may have upon which to draw conclusions in other lines of medicine, that it is difficult to get a unanimity of opinion as between 2 or more observers of this condition.

For instance, if it has happened that I have seen 2 or 3 instances where neglect to intervene has given the opportunity for development of a second phase of fulminance, which has perhaps cost the mother her life, that will color my whole viewpoint on the matter. While I said in my paper that we had seen a number of cases, after intercurrent eclampsia, go on to successful spontaneous delivery, we have been unfortunate enough to see 2 or 3 of the less successful group that I have indicated, and that has determined the practice indicated.

That is the only way in which I can apologize, perhaps, for not going wholly along with Dr. Bland in his refusal to intervene even after the condition has so much improved as to make the patient a reasonably safe surgical risk.

CESAREAN SECTION AS A POSITIVE FACTOR IN MATERNAL MORTALITY

J. Carlisle Brown, M.D.,
Atlantic City, N. J.

Studies by competent medical authorities indicate that there has been little or no improvement in obstetric death percentages, while other branches of medicine and surgery have shown marked advances. The lay press and the Federal Government have become interested in this subject and recently several articles, written by lay writers for the laity, all emphasizing the apparently inferior care given to child-bearing women in America and laying the responsibility squarely at the feet of physicians, have been published. It is, therefore, incumbent upon us, as scientific medical men, that we spare no effort in our search for means to rectify this unfavorable condition.

Much attention has been given to careful studies of cesarean mortality in large series of cases—notably by Thompson, Holland and Gordan—all of which show the general mortality from cesarean section to be about 10%. The purpose of this paper is to discuss the causes for this high mortality and to offer some suggestions for its lowering.

During the Middle Ages, the operation

was rarely performed, and only when all other methods of delivery had been tried and the situation was considered hopeless. The support given to this procedure by the Church, because it gave opportunity for baptism of the child, helped to keep it from absolute discard. Under such conditions a frightful mortality rate was to be expected. Even with modern surgical technic, few of these poor women would be saved. Their exhaustion, trauma from attempts at delivery, and infection from repeated examinations, would checkmate the finest modern surgery. The majority of these women died of hemorrhage and shock —since no uterine sutures were used—and the rest died of the infection which almost invariably set in. As late as 1884, Kayser, in Denmark, reported a mortality of 62% for the preceding 80 years. Murphy reported 86% mortality in Great Britain. Badin, in 1876, found that not a woman had survived in Paris between 1787 and 1876; and Spaeth made the same report from Vienna. Harris, in 1879, reported 80 cases in the United States with a mortality rate of 52%.

Since the high mortality rate was due to uterine conditions, either from hemorrhage or infection, it occurred to Porro, of Pavia, that the operation would be much safer if the uterus were removed and the vessels ligated, and in 1876 he published a description of the operation which still bears his name. The uterus was eventrated, opened, and following supravaginal amputation of the fundus the uterine vessels were ligated and the cervix stump fixed in the lower angle of the wound by skewers. The publication of his paper marked a dividing line in the history of cesarean section, for from that time the operative technic improved and with that the indications became more elastic. Sanger, in 1882, devised the first efficient method of suturing the uterine incision so that the lochia would not leak, a method which showed such good results that it soon relegated the Porro operation to its proper place, namely—to be used when the uterus, itself, is frankly infected.

Absolute obstruction to natural birth had been the only indication for cesarean section for 100 years. Then, late in the nineteenth century, with the discovery of bacteria and the development of antiseptic and aseptic surgery, the 2 large groups of patients covered in the toxemias and the hemorrhages of pregnancy, were added. To name the other indications for which cesarean section is now done would take hours. Some of them are, I fear, more often for the convenience of the physician than the patient. This multiplication of indications has naturally resulted in a marked increase in the incidence of cesarean sections, as is shown in the following figures (Chart 1):

CHART 1

	1916	1922	1928
Chicago Lying-In Hospital	0.9%	1.8%	3.0%
Hartford General Hospital	2.4%	4.2%	4.3%
	1912		
Nursery and Child's Hospital, New York	0.6%	1.6%	2.5%

Two of these hospitals are special, the other a large general one, but all show the same trend. With few exceptions, noticeably Minneapolis and St. Paul, this increase is general throughout the country.

The most striking change in obstetric practice during the past 2 decades has been the relaxation of indications for intervention during labor, and the great increase in operative deliveries. With the better training received by recent graduates, by improved technic, by hospitalization of patients with normal as well as abnormal conditions, one would expect a marked decrease in maternal and fetal morbidity and mortality; but, death certificates do not substantiate this conclusion.

Chart 2 shows the incidence of cesarean sections in different sections of this country and in some foreign nations:

CHART 2

	Total Deliveries	No. Cesareans	Per cent.
Detroit—Welz	33,480	154	0.46
Hartford—Miller	76,502	674	0.88
New Orleans—Miller	61,966	300	0.48
Massachusetts—DeNormondie	90,904	1161	1.28
Iowa—Plass	42,394		.70
(Birth certificate records)			Var 1.1
White House Conference Reports (119—General and Spec. Hosps.)	94,235	2714	2.9 to 14.9
Los Angeles—Thompson	33,874	1429	4.2

Brooklyn—Gordon	24,217	565	2.3
Montreal	4,025	178	1.7
Indianapolis	2,033	106	5.2
Minneapolis	26,885	70	.26
Stockholm Lying-In Hospital	3,148	2	.06
Willie	29,917	357	1.2
Jaschke	6,459	253	3.9

With exception of the Iowa figures, which were taken from birth certificates, and those from Stockholm, these figures were taken from hospital statistics and reported, in all instances, by dependable physicians.

Why This Wide Variation and of What Significance?

Numerous factors seem to enter into these figures. Besides the real obstetric indications, manifold excuses crop up. (1) I believe the first idea is that a woman should have her baby without pain. Unfortunately, much misinformation about painless child-birth has reached our patients through quasi-scientific articles by lay writers in the popular press. In my opinion there is no single method of administering any anesthetic during labor that does not slow, and occasionally stop, labor; and when labor is slowed or stopped the proportion of operative deliveries increases. There is no "royal road" to maternity. (2) Demand by patients for a shorter period in labor. (3) The false sense of security derived from modern surgical technic and supposedly reliable antiseptics. (4) Among some operators and nurses, there has arisen an impression that cesarean section is a harmless procedure; which mistaken idea, though utterly contrary to the facts, is becoming more popular among women in general. It is a frequent occurrence for women to ask the physician, at their first interview, if it is not best to have a cesarean section primarily; which immediately puts the physician on the defensive, and from then on any complication arising during delivery will be place squarely on the poor judgment of the obstetrician. (5) Stretching indications to suit the convenience of the patient or the doctor; such conduct is entirely too frequent. (6) Gossip—the apparently natural tendency of women in general to brag about and exaggerate all the marvels and horrors of child-bearing. It is unfortunate that only those who survive can tell their story. (7) Lastly, the exaggerated importance of the child as compared to the life and health of the mother; nearly all of the newer indications, except those in the convenience group, should be classed as fetal. In every case where a cesarean is done for the baby's sake, we should weigh carefully: the chances for death of the mother; her loss of fertility; her inability to have more children in the natural way; against the value of the life of any one child.

We have seen the increased incidence of cesarean sections and discussed some of its causes. Let us look now to the results.

CHART 3

Mortality

	Rate
Detroit	13.0
Hartford	4.5
Indianapolis	11.3
St. Paul, Minnesota	5.7
Los Angeles	4.2
New Orleans	16.1
Houston	14.4
Massachusetts	8.8
Springfield, Massachusetts	4.8
Wisconsin	15.1
Great Britain	7.2
Germany	7.1
Children's Bureau	10.7
Gov't Statistics, 136 Hosps.—1929 Questionnaire	19.4
Greenhill—Chicago Lying-In	1.7
Williams—Johns Hopkins Hosp.	3.4

The most striking fact about cesarean sections is its mortality. Its morbidity, subsequent semi-invalidism, mental anguish about recurring pregnancies, and the abnormal sexual life which that entails, can never be accurately determined. These uncorrected maternal mortality figures have been collected by competent men in widely separated parts of the country. They are taken from cities as a whole and are, of course, from hospitals. They represent all types of operators and all kinds of hospitals. However, it may be assumed that they are from the better hospitals, since the figures are in most cases taken from carefully examined histories.

In contrast to the results in the country as a whole, are the percentages of Greenhill and De Lee, at the Chicago Lying-In, and of Williams, at the Johns Hopkins Hospital. It must be remembered that these 2 clinics rank among the best in this country and represent the ut-

most in obstetric judgment and operative skill.

Why do so many women die after cesarean section?

CHART 4

Figures Characteristic of All Reports

	Holland—1953 Cases England		Gordon—934 Cases Brooklyn	
(1) Not in labor	1202	1.6%	343	3.5%
(2) Early in labor	389	1.8%	110	6.4%
(3) Late in labor	220	10. %	403	7.7%
(4) After induction of labor	35	14. %	1	0.0%
(5) After attempts at delivery	29	27. %	14	13.6%

This shows the mortality rate in cases of contracted pelvis, when the operation is done at different times during labor and after various maneuvers aimed at delivery.

CHART 5

Shows the Mortality in Eclampsia after Cesarean Section

		Cesarean	Conservative
Williams—Johns Hopkins Hosp.	275	25. %	8.6%
Los Angeles General		35. %	7. %
Humpstone—Brooklyn Hosp.	40	33 1/3%	14. %
New Orleans—Miller	41	41.5%	
Detroit—Wentz	26	42.7%	
Brooklyn—Gordon	104	26. %	
Greenhill—Chicago Lying-In		6.3%	

About the year 1910, this indication for cesarean became very popular and an uncounted number of these operations were performed, but in the light of comparative statistics, including a large number of cases, the trend is now decidedly away from cesarean section in eclampsia.

I will not discuss the hemorrhages of pregnancy because of the conflicting opinions. Some operators always do cesarean sections in cases of placenta previa; others never; and the results appear to be about the same in so far as maternal mortality is concerned. Here again, however, appears the choice of the mother against the fetus.

Summary

Obnoxious as statistics often are, and irrespective of our personal opinions, these figures indicate that the mortality rate of cesarean section in this country lies between 7% and 10%—probably nearer to the latter figure. If there are 2,500,000 children born each year, and the average incidence of cesarean section is 1%, then 25,000 sections are done each year, with an average of 2000 maternal deaths. If the Minneapolis-St. Paul figures be taken as the limit of conservatism, then ¾ of those 2000 cesarean sections were unnecessary, and undoubtedly add to our disgraceful maternal mortality. These reports also indicate that by far the most favorable figures are presented from well-regulated Obstetric Clinics where the indications are more clearly defined and the operation chosen which is best adapted to the particular patient. We must not be misled when reading these reports. Doing a version only occasionally, we cannot expect to perform as well as Dr. Potter, who does, perhaps 1000 annually. With inhalation anesthesia, and with all sorts of indications and complications that can be judged only by trained obstetricians, the casual operator cannot expect to approach the figures of Dr. De Lee, whose skill, both as an obstetrician and a surgeon, is known world-wide, and who operated on 90% of his patients with novocaine infiltration anesthesia alone. Prophylactic forceps, version and cesarean section are operations to be done by men with a clear understanding of the indications, and with the ability and the judgment to perform them in the interest of the patient.

Too often, I fear, we are influenced by the apparent ease of the operation. From the operator's point of view, there is no comparison between the difficulty of a cesarean section and that of a version and extraction, or forceps; not to mention the difference in fees. Our graduates know how to conduct a labor; they know what causes puerperal sepsis and how to avoid it; they do rectal examinations; yet they immediately fly to an operative procedure for the most trivial abnormality.

Radicalism in obstetrics has been built up rapidly during the past few years. To expect that this enthusiasm will wear itself out quickly, is to expect too much. Plass says: "For permanent and lasting relief, a return to first principles is necessary. It should be taught that any interference with normal labor carries a definite risk. This educational program should be carried to the medical profes-

sion at large, but, especially, to the laity who, after all, largely determines the character of medical practice."

In Joseph Warrington's Obstetric Catechism, published in 1842, where the question is asked—"What influence is the practitioner to exert in normal labor?"—the answer is: "A negative influence, rather to prevent than by being himself very active." And, from Elizabeth Uphill's "Treatise on the act of midwifery", published in London in 1760, we find: "In this, there are some of them but too near upon a level with the man midwife, with the difference, however, in favor of the female practitioners, that they are incapable of doing so much mischief as the males, oftenest more ignorant than themselves, but who with less tenderness and more rashness go to work with their instruments."

DISCUSSION

Dr. A. B. Davis (Camden): Dr. Brown has given us a very good paper, one that is very timely, and one with which we can, in general, agree. It is, as he said, based mostly on statistics, and we all know how unreliable they may be. But yet, it is only by going over our statistics as carefully and honestly as possible, and by checking up on ourselves and our work, and comparing it with the reports of others, that we can tell where we are, what we are doing, and whether we are doing the right thing. So, I shall take the liberty of adding a few more statistics here in discussing his paper, and I think we can mention some interesting points and then possibly draw some conclusions.

The Philadelphia Obstetric Society has just completed a survey of all the cesarean sections done in Philadelphia during the year 1931. This work has been done very carefully and has been checked against the "vital statistics" over there; and through the kindness of Dr. Lull, Chairman of that committee, I have here the record of that work.

The total number of births in Philadelphia, 35,-284; those occurring in hospital number 23,511—which is about 2/3; a much higher incidence than could possibly have been brought about only a few years ago. Total number of cesarean sections, 573; a percentage incidence, in the whole city, of 1.6%; and, of the hospital deliveries, 2.4%. Approximately the figures that Dr. Brown quoted from some of the other cities.

We have also the data for the City of Camden, last year 3024 births, and of those, 1082 were in Cooper Hospital. There are 2 other hospitals in Camden, the West Jersey and the Bellevue, which would account for probably nearly as many more, and that would run almost the same percentage as given for Philadelphia. The cesarean sections done at Cooper numbered 46, which would be an incidence of 4.2% of the hospital deliveries; a little higher than the table shows for Philadelphia.

In a table showing the percentage of cesarean sections to total deliveries, in more than 40 Philadelphia hospitals, we find, as Brown suggested, that the figures vary considerably in different institutions; for instance, from 2 sections in 264 deliveries, less than 1%—to 7 sections in 42 deliveries, which is more than 16%. An average of 2% in a large hospital reporting 1523 deliveries, is fairly typical. The high percentage quoted above (16%) seems difficult to justify but, that hospital *may*—we do not know—receive an unusual number of patients with difficult or emergency conditions.

There were 25 hospitals having no deaths at all, but about 10 of those had no sections; leaving 15 where there were a large number of deliveries, and 184 sections with no deaths. That speaks well for those hospitals. In Cooper Hospital, in Camden, we had last year 46 sections with no deaths.

Dr. De Lee says, about the use of forceps; that men who know how to use forceps, probably don't use them often enough; whereas those who don't know how, probably use them too frequently. There may be something of that in relation to cesarean sections: that the men who have not had proper experience, tend to rush, as Dr. Brown said, to a section; while those experienced in their performance, are possibly oftener sorry that they did not do a section, than that they did.

In this table of indications you will note, as Dr. Brown brought out, that there is a very great increase in the indications for section. Almost everything is taken, one way or another, to indicate—or in some cases you might say *to excuse*—the performing of a section. That is, of course, justified to some extent because the operation is so much safer than it used to be, but we can't help but feel that in a great many instances it is not indicated, or, that the indication given is not one that an experienced obstetrician would consider an indication for section, and that the advice of such an experienced obstetrician would have been to undertake another form of delivery. Undoubtedly, this greatly increased number of indications has increased the mortality rate.

As to causes of maternal deaths, sepsis is the chief, the thing we always have to fight against in all forms of delivery, and which, of course, in cesarean section has the added chance of the opening into the peritoneal cavity—certainly a thing to be very seriously considered. The patient subjected to section has, no matter how careful the technic of the operating room and all that may be, the added opening into the peritoneal cavity through the open cervix and the uterine cavity, as an additional channel for infection to enter, and there will always be a considerable mortality because of that possibility of infection from below.

Here is, I think, a very interesting point to be brought out. The *high section* was done 458 times and the *low* 103 times; celiohysterectomy (Porro) 10, and 1 vaginal hysterectomy. You will notice that the *high operation* gave a mortality of 6.3; while the *low* gave a mortality of 3.8. No one should do a cesarean section, except in great emergency, who doesn't do, or who would not be competent to do, the *low operation*. I think the *low* operation is the one of choice in practically all cases, unless there are contraindications or some reason for great haste, or some very special reason for doing the *high* operation.

As Dr. De Lee says, if the low operation is good or better for the infected patient, why is it not better in all, because every such woman is a possibly or a potentially infected patient. I think that is one reason for our good results last year at Cooper. Out of 46 sections, we did the high operation 21 times, mostly on private patients, though by several operators; and the low section, 19 times, mostly for ward patients.

We did a median operation, or practically Dr. Piper's operation, 6 times. If there are available statistics on that operation, I think they will show a better mortality rate and less probability of infection than the classic high operation. Our table shows about ½ the mortality in the low operation that there is in the high.

Anesthetics used: Gas-ether, 31; ether, 154; local, 46; nitrous-oxide, 43; spinal, 14; and, ethylene, 5. In that we have quite a variation from what our records showed last year, and again, I think the question of anesthetics helps to explain our low mortality rate. I think that many times the use of ether is more of a shock or a greater cause of morbidity than is the operation. I notice, in Philadelphia, there is comparatively little ethylene used, and few spinal anesthesias. We have used a good deal of each in Camden. For our 46 sections, we had 24 spinal anesthesias; 16 ethylene; 4 nitrous-oxide; 2 of gas-ether; and, 2 of gas-oxygen.

The mortality rate for the babies averages about 502 live-births to 74 still-born or dead within a few days; corrective fetal mortality being 6.2, which is probably better than the average in some other cities.

Dr. R. A. MacKenzie (Asbury Park): A discussion of this paper would not be complete without some mention of the extraperitoneal cesarean operation; an operation which has not received the attention it merits generally, because it does not necessitate any invasion of the peritoneal cavity. I am a firm believer in conservative obstetrics and I believe we are all very much impressed with the statistics offered by Drs. Brown and Davis. I have personally reviewed the statistics of cesarean operations in Monmouth County for the past 5 years, and I am impressed, not so much by the unfavorable end-results as by the fact that the indications are not those which would stand the test of critical examination. I do not believe that anyone, with the widest clinical experience, even with the help of such excellent roentgenologic pelvimetry as was demonstrated this afternoon, can invariably predict the course of labor. There are a great many women with moderate contraction of the pelvis where a thorough test of labor is necessary, and we all appreciate that a test of labor is not conclusive until the cervix is completely retracted and dilated and until the membranes have been ruptured.

If the extraperitoneal cesarean operation is known and can be employed, then the obstetrician feels thoroughly at ease in permitting his patient to labor until that degree of dilatation has been accomplished; and he feels perfectly safe also in artificially rupturing the membranes and then waiting a further period of time to see if the fetal head will engage and a normal delivery will result.

In 1922, Dr. C. F. Jellinghaus, of the New York Lying-In Hospital, developed a modification of the original Latzko technic for this operation, and it received favorable attention, but lately, through the larger series of cases presented by Dr. Henry Burns and Dr. Kyle Steele, before the New York Obstetric Society, the operation has been shown to be very much safer than it was ever imagined. It is not a procedure to be used, of course, in an elective case, for considerable retraction of the cervix is necessary to make it possible to push the bladder away from the anterior uterine wall, and give exposure sufficient for a vertical incision through which the baby may be delivered without tearing the peritoneum. But the operation is eminently satisfactory in neglected cases, for patients, that is, whose labor has been long, and where delivery by abdominal section is indicated.

May I repeat that an appreciation of this operative scheme, and its proper application, may reduce the frequency of elective or early cesarean delivery and lower the morbidity of abdominal section in late cases.

Dr. E. G. Waters (Jersey City): Controversial opinion is naturally to be expected in the discussion of cesarean section and especially so in any statistical study of the subject. I think that statistics are valuable when to them is relegated their proper value and I think a proper evaluation of any statistics concerning cesarean section as compared to other types of delivery should include not only the immediate but the eventual mortality as well as morbidity. Here we see compiled some very valuable data on cesarean section. We do not, however, see contrasted with it the inevitable morbidity, the inevitable immediate mortality, and the inevitable late operative mortality which complicates injudicious selection for vaginal types of delivery in cases where cesarean section had so much better been done.

I am mainly, obstetrically speaking, from the hospital with which Dr. Cosgrove is associated and I think we are reasonably conservative, but to us—or, I will speak for myself and say—to me,—there is little choice between cesarean section done in good hands for a clear-cut, distinct indication, as compared to a difficult vaginal operation on a patient whom you may deliver successfully as far as she and her baby are concerned, but whom you may leave with injured, bruised tissues which will only, after a period of months, give to you the true damage that she has sustained at the time of delivery.

There are a few other things that one should think of in questioning or in analyzing any statistical data such as have been presented here.

You might ask the questions in a few words: You may say: Who, Why, and How? Who did the operation? Was it a general surgeon or was it a competent surgical obstetrician, or was it a man who does obstetrics?

Curious as it may seem, an analysis not so long ago showed that cesarean section at the hands of general surgeons has a better operative result, if you consider results in the terms of mortality statistics, than the same operation done by obstetricians. And if you will think just a moment, it is not so strange, because from the standpoint of surgical technic, surgeons, we must admit, are likely to be more competent in the handling of procedures involving abdominal technic than is the average obstetrician. However, when you ask the question—"Why?" it is amazing that the general surgeon enjoys such good results, when I sometimes see the bizarre indications which seem to enter into his selection of the type of interference to make in a given case—all too frequently, cesarean section.

And the third question—"How?" involves something which several speakers have touched upon almost sufficiently. I seldom use the classical type of operation. I haven't used it for 5-6 years at our hospital, where it is almost routine to do the low transperitoneal laparotrachelotomy, and for the past few years most of the attendants have been using the transverse incision which makes it a true retroperitoneal incision, as contrasted with the 2-flap operation. With the low transverse incision, as dwelt upon so extensively by Phaneuf,

you have an incision which is essentially through the cervix and an incision which at neither end is extended upward into the peritoneal cavity, and at the termination of the operation is entirely concealed by the bladder, and usually at the termination of the operation it has a double layer of peritoneum. So, I think that, in reviewing any such statistical study as we have seen, excellent though it may be and undoubtedly is, we should hold in mind not only the immediate mortality, but also the mortality as compared to how those patients who were sectioned would have fared had they been delivered vaginally, holding in mind the inevitable mortality, immediate and eventual, which would have succeeded, and also the morbidity which might make some of these women wish often they had died.

You should think: Who did the operation? Why did he do it? What kind of operation did he do? You should put those 3 questions before passing finally on the question of whether too many sections were done or are being done.

PROGRESS IN PREVENTION AND CONTROL OF ECLAMPSIA*

J. O. Arnold, M.D.,
Professor of Obstetrics, Temple University Medical School,
Philadelphia, Pa.

* * * How benevolently the pendulum of medical thought and practice tends to swing back from uncertain and dangerous extremes toward the mean of safety and reasonable certainty, is perhaps nowhere more strikingly shown than in our present-day tendency to return to the position of the fathers on the age-old questions involved in the *cause* and *treatment* of eclampsia.

Even the briefest survey of the past 8-10 decades of our ever-changing attitude on this subject, is enough to warrant a belief that this return move is a *wise* one, and one fraught with considerably more encouragement and hope for the ultimate solution of the problems involved than any other step in recent years.

In the earlier half of the past century, there was little difference of opinion among the best clinicians as to the essential factors producing the condition known as "puerperal convulsions". The highest obstetric authorities of both Europe and America were well nigh of one opinion when they declared that this most tragic complication of pregnancy was undoubtedly of cerebral or brain-pressure origin. As one of them very tersely stated: "Puerperal convulsions arise, it has been almost universally believed, from congestion of the blood vessels of the brain, or from actual effusions of serum or blood into its substance or cavities. * * * I have long been of the opinion that the increased excitability of the nervous system generated by pregnancy (which is very analogous to that of the young child—easily excited to convulsions from comparatively trivial causes), together with the natural tendency to plethora and increased vascular excitement seen in all cases of pregnancy, constitute the predisposing causes of puerperal eclampsia. * * * Such nervous irritation and vascular congestion not only interfere with the functions of the brain, but these changes are often followed by *watery,* or *bloody effusion,* augmenting to a still greater degree such functional disturbances. * * * Should the brain be, therefore, the seat of irritation from a moral cause, followed by congestion, and especially by sanguineous effusions, the cerebral functions will be correspondingly deranged as manifested by headache, delirium, convulsions, coma, and it may be, *death.* * * * Examinations after death, in a number of such cases, have shown no lesions whatever except effusions on the surface of the brain, especially toward its base, and in the spinal canal. They are also occasionally found in the ventricles, to the extent of 6, 8 or more drams. In a few instances, blood is effused on the surface, and in the substance or cavities of the brain. * * * The correctness, therefore, of the above expressed opinion, is, we think, sustained by the whole history of puerperal convulsions, and forms the best foundation for those principles which will be the surest guide to the practitioner in his contest with this frightful malady."

Thus spoke one of the greatest obstetricians of the Nineteenth Century, Dr. Hugh L. Hodge, Professor of Obstetrics in the University of Pennsylvania from 1835 to 1863, and thus believed the majority of his contemporaries at home and abroad, until about the year 1842, when, from the resemblance of uremic and puerperal convulsions, and from

*(Résumé of an address before the Cumberland County Medical Society, July 12, 1932.)

the observance of albuminuria in both conditions, there was proposed, for the first time in the history of the disease, the disconcerting, but none-the-less alluring theory of a *poison* in the blood of the pregnant woman; *a kidney poison*—uremia for instance—at any rate, a "toxic anemia" of some sort, that would account for all the trouble known as "eclampsia", and its fore-running preëclamptic morbidity.

One can readily understand how this new theory would so easily gain a foot-hold. There was no question among those early obstetricians as to the correctness of their clinical observations, findings, and conclusions. Undoubtedly, there was cerebral congestion, and edema and effusion, and the typical "wet brain" at autopsy. Nor was there any doubt about the value of certain distinctive features of their treatment, such as purgations, and copious bleedings—fluid depleting, and brain-dehydrating agencies; but modern physiologists and neuro-surgeons had not yet demonstrated the principles of water-balance in the human economy, and the relationships of fluid-intake and output,—of water distribution, and storage, and especially of water-balance as related to the newer conceptions of kidney function.

All this was unknown to these earlier clinicians, and because it was unknown—because they had the truth, but not "the whole truth", their efforts, like ours today, were not always as successful as could be desired. It was but natural, therefore, that some—the pathologists especially—should be more attracted by this new idea of another and entirely different sort of cause, than by the problems involved in working out a more perfect understanding of a cause already known and recognized.

But, of course, it was soon found that albuminuria—uremia—as the cause of eclampsia, could not be successfully defended or maintained. As one of the shrewd observers of the day put it, "Albuminuria is simply indicative of congestion of the renal vessels—part of the general plethora, and has no necessary connection with toxemia in any of its supposed forms. * * * Along with its accompanying anasarcous swellings, it should be regarded as the evidence of *hyperemia* and *not* of *toxemia*, and therefore, this *uremia* notion soon had to be abandoned, and some other *poison* sought to meet the conditions of the new hypothesis."

And thus began so long ago, the most *famous* and baffling toxin-hunt in the whole history of medicine. From that day to this, pathologists throughout the world, have been vainly searching for a "puerperal poison" that would produce the effects, or meet the conditions necessary to maintain the idea of a "toxemia of pregnancy".

Is it not strange that so potent a poison should have remained so inextricably hidden through all these years? No wonder we so seriously question, any more, whether there *is* a poison, or whether, as Zangemeister has said, it is not a "water intoxication".

No wonder we are so rapidly coming to the conclusion that the original conception of this whole problem was much nearer to the truth than any of the fanciful theories that have come and gone—or come and remained—in the past half century!

It seems to me that we could scarcely characterize the situation as we find it today, in better words than those used by Hodge nearly three-quarters of a century ago:

"Modern *theorists* consider puerperal convulsions to be the result of a toxemia, or blood-poisoning, but the evidence of any poison or malcondition of the blood is exceedingly meager. * * * Toxemia appears to have been *inferred,* rather than positively proved."

Your speaker feels that after all these years, that pronouncement may be reiterated with all its original emphasis, *and more.*

You will not wonder, I am sure, that with this historic background in mind, and knowing that the brain-pressure conception of eclampsia has not only persisted through the years, but has been actually verified and strengthened by every step in the advancement of our knowledge of the physicochemical processes of the body, we were quite ready to consider with keenest interest, the clinical investigations, and animal research studies of Weed, Rountree, Kubie, Gamble, Freemont-Smith, and many others who, in the past 5-10 years, have done so much to enlarge and clarify our knowledge of the physiology of the

brain in its varied and very important relationships to the amount and distribution of body fluids, and to the principles concerning hydration states, and their prevention and control by fluid-balance methods. And we do not hesitate to say that we believe this brain-study, kidney-function, water-balance work of the past few years, has, undoubtedly, supplied the one very vitally important factor that was lacking in the days of the fathers, to make their conception of the cause and treatment of eclampsia complete.

Attracted and inspired, therefore, by these more recent physicochemical studies, and especially by the very practical achievements of my colleague, Dr. Temple Fay, and his associates, in the field of epilepsy, brain-injuries and other convulsive states, and guided by Fay's kindly personal assistance, we began, something over 2 years ago, to apply the principles of *water-balance* and of *cerebral dehydration* in the prevention and control of eclamptic convulsions, in all cases of so-called "late toxemia of pregnancy" coming under our care in the Temple University Hospital and the Greatheart Maternity.

To say the least, we have been greatly pleased and encouraged with our results—so much so, that we want you to know our methods and apply them, and test their value for yourselves—and report to us, if you will, on your results, good or bad.

The following is an outline of the chief points and principles involved in the course we have pursued:

(1) An effort has been made to place all maternity patients in one or the other of 2 general groups: (a) Those who were free of organic disease (especially of the kidneys) before pregnancy; (b) those who have a history of organic disease, or of nephritis-producing disease, such as scarlet fever, before the present pregnancy.

(2) As pregnancy progresses, the patients in each of the above general groups have again been separated into 2 distinct classes: (a) Those who remain in their normal or usual health throughout pregnancy, labor and the puerperium; (b) those who develop, sooner or later, some degree of eclampsism—the so-called "toxemia" of pregnancy.

(3) Eclampsism or preëclampsia, leading up to and culminating in the convulsive state known as *eclampsia,* has been considered and treated as but one condition, or "symptom complex", in varying degrees of advancement and severity. For practical purposes, these stages or divisions as to severity, may be classed as: (a) The moderately preëclamptic stage; (b) the dangerously threatening pre-eclamptic stage; (c) the eclamptic or actively convulsant stage.

(4) There has been discovered up to this time but one essential and constantly present difference between the patients who have eclampsism, and those who do not, and this is, the difference in the amount and distribution of the surplus water in the interstitial spaces of the body—including, of course, the cerebrospinal fluid system.

(5) This *water-imbalance,* and its consequence, cerebral edema with brain pressure, in patients hypersensitized by pregnancy, is, we believe, the *immediate cause* of the varying symptoms and conditions characteristic of eclampsia, and its forerunning preëclamptic morbidity, including its secondary effects on the kidneys, liver, and other organs.

(6) While the immediate or *proximate cause* of eclampsia has thus been definitely assigned to edema of the brain—to water-imbalance—rather than to any long-sought-for specific toxin in the blood, we can declare with equal frankness, that the *remote* factor (or factors) involved in the production of this trouble-making fluid-imbalance, *is not yet known.* The hypersensitive state of the nervous system produced by pregnancy, and aggravated by the pain and excitement incident to labor, is often, undoubtedly, an *important predisposing factor,* but we still await further physicochemical revelation that will take us all the way back to the *real genesis* of the difference between normal and abnormal water-elimination, water-retention, and water-distribution, in the body of the pregnant woman; *and* of the *factors that control* these processes.

(7) Whatever the physiologist may thus reveal to us in the future, the obstetrician has

now, in the control of the intake of food and drink, and in the methodic application of the principles of fluid-balance, a very *definite* and *practicable* means of preventing the so-called "toxemia of pregnancy".

(8) Where a dangerous degree of fluid-imbalance already exists, as manifested, for instance, by convulsions or near-convulsions, we have in the early and thorough application of the well-known methods of cerebral dehydration, a *safe and all-sufficient means* of promptly affording relief, or controlling the seizures, and securing the mental restoration and lasting improvement of the patient.

(9) The methods found to be most effective for rapidly dehydrating the eclamptic brain, are:

(a) The intravenous use of hypertonic solutions of glucose (50 c.c. doses of 50% solution), and magnesium sulphate (20 to 30 c.c. doses of 10% solution); the *latter* less valuable and probably more dangerous, and the *former* to be used purely for the purpose of, and only to the extent necessary for, the abstracting of water from the tissues into the blood-stream, so as to make it available for early elimination by bowels, kidneys, etc.

(b) *Spinal drainage,* as completely as possible, and repeated if necessary, at 3 to 6 hour intervals. (Blood-letting may sometimes be substituted, when spinal drainage is found to be impracticable.)

(c) Early and repeated purgation (saturated solution of mag. sulph. by mouth or bowel) as indicated for augmenting or continuing dehydration beyond that of the kidney output.

(d) *Absolutely no other fluids*—or foods—for at least 24 hours (often much longer), making careful observations, especially on pulse-pressure, and output of water from bowels and kidneys.

(e) When the convulsions have been controlled, and the 24 hour urine output is known, resume the giving of fluids at 3 hour intervals in daily amount not greater than the previous day's output, gradually resuming feeding at these intervals also.

(f) If dehydration has been thorough and effective, the uterus need not be emptied, nor labor induced or hurried, except for reasons other than the attack for which the patient is being treated.

(10) An outline of treatment follows.

All treatment is based on the more recently demonstrated fact (Fay and Arnold, Temple University Hospital, 1930-31) that the *immediate* cause of this condition (remote factors not yet known) is a systemic *water imbalance,* which results in varying degrees of cerebral edema and brain-pressure, with its consequent clinical phenomena.

Consider every patient, therefore, from the standpoint of the amount and distribution of surplus water in her tissues.

Make careful observations and records of: (1) Blood-pressure—at least every 2 to 4 hours. (2) Urine output. (3) Fluid-intake. (4) All complaints and symptoms—pain, headache, vomiting, stupor, disturbed vision, convulsions (number, frequency, duration, and degree of severity).

Preëclampsia, of whatever degree, leading up to and culminating in the "convulsive state", eclampsia, is best considered and treated as but *1 condition,* in varying degrees of severity, or stages of advancement, as:

(1) The moderately preëclamptic stage.

(2) The dangerously threatening preëclamptic stage.

(3) The eclamptic, or actively convulsant stage.

The outline of treatment for each stage is as follows:

First stage: (a) Withhold (or restrict to a minimum) all fluids until the 24-hour urine output is known.

(b) *Total fluid intake* in next 24 hours, is not to exceed previous day's output of urine.

(c) *Chart accurately* the daily *intake, output,* and *weight,* and maintain, as far as practical, a balance of fluids, and a control or reduction of weight.

(d) *Dehydrate moderately* with small daily doses of saturate solution of mag. sulph.

(e) *Give salt-low* diet—comparatively dry or solid fluids of wide variety, *including proteids,* and excluding ice cream and other sweets.

(f) *Allow small meals,* at 3-hour intervals throughout the day, with no food *or drink* at any other time.

SECOND, OR DANGEROUSLY THREATENING STAGE

Follow the same general principles as for mild cases, but add the following more immediately effective measures:

(a) *Begin at once* to dehydrate by giving intravenously 50 c.c. doses of 50% glucose, and repeat the same in 4 to 6 hours, if necessary.

(b) *Give mag. sulph.* (saturate solution) by mouth, until effective in watery stools. Repeat daily, or as indicated. (*Rarely,* 1 or 2 20 c.c. doses of 10% solution mag. sulph. intravenously, may be substituted.)

(c) *If very urgent,* or no marked improvement is seen in 15-30 hours, do *one* or *more spinal drainings,* at 4 to 6 hour intervals.

(d) *If spinal drainage* is impractical, *venesection* may sometimes be substituted, but not where labor is well established, or early delivery is anticipated.

(e) *When the immediate* danger has been abated, keep a careful *weight chart,* and maintain a strict fluid balance throughout the remainder of pregnancy.

THIRD, OR CONVULSANT STAGE

(a) *If absolutely necessary* to facilitate other treatment, begin with a *sedative intramuscularly.* (Sodium luminal gr. ii to gr. iii, or very rarely, morph. gr. ¼ to gr. ½.)

(b) *Give at earliest possible opportunity,* 50 c.c. of 50% glucose intravenously. (20 c.c. of 10% mag. sulph. may sometimes be substituted, or added.)

(c) *Drain spinal fluid* as completely as possible (45 to 100 c.c.) preferably with head raised to an angle of 30°. (When spinal drainage is impracticable, venesection may be substituted.)

(d) *Repeat glucose* in 3 to 4 hours, and spinal drainage in 4 to 6 hours, if marked improvement is not seen.

(e) *Give mag. sulph. Purge* at earliest opportunity, and repeat as indicated for continuing dehydration.

(f) *Absolutely no other fluids* are to be given for at least 24 hours, and careful record kept of T. P. R. and pulse-pressure.

(g) *If dehydration* has been thorough and effective, the uterus need not be emptied, nor labor induced or hurried, except for reasons other than the attack for which the patient is being treated.

Those interested in a more complete discussion of this whole subject than has been possible on this occasion, are referred to the paper on "Eclampsia" by Arnold and Fay, in the August 1932 number of "Surgery, Gynecology and Obstetrics".

CLINICAL ANATOMY AND PHYSIOLOGY OF THE COLON

VICTOR KNAPP, M.D.,
Asbury Park, N. J.

In the short time allotted me, it will be possible to mention, briefly, those points in the anatomy and physiology of the colon which have a ready clinical application, without enlarging on the subject to any extent.

The position of the colon in the abdomen in relation to the other organs, and to the subdivisions of the peritoneal cavity, is a matter of individual architecture. It is just as true of the colon as it is of all other organs of the body that the habitude of the person determines the size, shape, and position of all his viscera. Taken in this light, ptosis becomes a diagnosis that is rarely, if ever, justified. Those individuals who are asthenic, and who have not only low-placed colons, but also long fish-hook stomachs, and often a floating, palpable right kidney, do exhibit, quite frequently, symptoms referable to both their digestive and nervous systems. These patients are not suffering as a result of the low position of either their colons or of any other organ, but their particular type of build allows for no other shape or position of their viscera, and their complaints must be attributed to what we are pleased to call constitutional inadequacy or inferiority.

The cecum and iliac colons are normally palpable. The cecum lies close to the anterior abdominal wall, and this explains the frequency of fistula in that location.

In fetal life, the cecum has a mesentery, and where this persists, volvulus in that region can occur. A clew to the high position of the cecum, in cases of arrested descent, is had from the discovery of an undescended right testicle. Were such a person to develop acute appendicitis, the signs would be in the right upper quadrant. Because the cecum lies on the right psoas muscle, inflammatory lesions there may cause adhesions to the muscle, and that would account for their pain on walking.

The sigmoid is the most freely movable segment of the colon, the most readily distensible, and the usual site of volvulus. The distal colon is the last and slowest portion to develop, and so it is the part most frequently involved in absent or arrested development. The concavity of the sacrum is less in children and in women; therefore, prolapse of the rectum is more frequent in them than in men.

Venous return from the colon is through the superior and inferior mesenteric veins, and thence into the portal vein. Infections of the colon or parts thereof can and do cause serious and even fatal thrombophlebitis. Such complications are met with, for example, in acute appendicitis and cases of infected hemorrhoids. In the operation for acute appendicitis it is suggested that the ileocecal vein be ligated, to ward off such complications. The superior hemorrhoidal vein is a part of the portal circulation, and the middle and inferior hemorrhoidal veins are part of the systemic circulation. This immediately indicates the veins involved in hemorrhoids the result of cirrhosis of the liver and other portal obstructions, and those concerned in circulatory insufficiencies. To patients who require digitalis, but in whom such medication causes nausea and vomiting before its desired effects are manifest, it may be given per rectum and avoid having to pass through the portal circulation.

The nerve supply of the colon is from the sacral cord, through the pelvic nerves, which supply the motor or excitatory fibers, and from the lower lumbar sympathetics which supply the relaxing or inhibitory fibers. Some work, not conclusive, has been done suggesting that the vagus supplies the colon as far as the hepatic flexure. The sacral fibers end in Auerbach's plexus, and it is probable that it is through this plexus that stimuli act on the bowel. Meissner's plexus, situated in the submucosa, controls secretion. The nerve supply to the colon acts as a check upon it, to prevent its reaction to every stimulus that reaches it. If it were not for this provision, we would all die from diarrhea and inanition. All sensory stimuli that affect the body stimulate also the sympathetics of the bowel. For example, painful stimuli cause inhibition of the bowel by their action on the sympathetic. Here opium, which removes the stimulus, causes a bowel movement, whereas a cathartic is ineffectual. It is well known that in a general anesthesia which inhibits the sensorium, but allows painful stimuli from the peritoneum to be conveyed to the cord, the intestinal tract is quiet. But in a spinal anesthesia where the sympathetics are blocked, the intestine is active. Also, paralytic ileus occurs frequently in general anesthesia. It has been suggested that in obstinate cases of paralytic ileus, following general anesthesia, spinal anesthesia be induced to block the sympathetics and restore the muscle to normal activity. That this type of ileus is not due to muscular weakness or its inability to contract, is well known. A resected piece of gut of an animal suffering from paralytic ileus will begin to contract when placed in oxygenated Locke's solution.

A center in the fourth ventricle, near the respiratory center, has been described as controlling defecation. It is probably through this agency that respiration is stimulated where forceable dilatation of the anal sphincter is employed in resuscitation.

That the emotions are potent in the alteration of colonic function is too well known to require any detailed comment.

The lymphatics of the hepatic flexure communicate directly with those of the right kidney, and direct extension of infection with the colon bacillus can be carried from this segment of gut to the right kidney.

The chief function of the colon is storage,

absorption in its proximal portion, mostly, and the excretion of some heavy metals. The function of the ileocecal valve is to withhold contents from the cecum until ileal digestion and absorption is complete, and to prevent regurgitation of cecal contents. Whether or not ileocecal regurgitation can take place under normal conditions is a moot point. While one sees regurgitation quite often after an opaque enema, it is to be remembered that an abnormal means of filling has been used; one that has no counterpart in Nature. In patients with cecal fistula it is observed that about 350 c.c. fluid contents reach the cecum in 24 hours, and that this fluid chyme contains some coagulable protein, some carbohydrate, some fat, and cellulose. The feces average 135 gm. in 24 hours, and are devoid of coagulable protein and carbohydrates, but contain 75% of water; whereas, the cecal contents are 90% water. It is well known that patients with cecal fistula suffer greatly from thirst, and some cases of diarrhea are thought to be caused by failure of this absorptive power.

An alkaline viscid secretion has been described as originating in the cecum, and its absence is thought to have an etiologic bearing upon some cases of chronic ulcerative colitis. The skin maceration and irritation common in cecal fistula is explained by the absence of this same secretion.

The importance of the bacterial content of the colon, as to numbers and kinds, is still being argued. That the colon is possessed of a very finely balanced mechanism, one that is easily upset, is well known, though it is forgotten all too often. The normally intact and unirritated mucosa offers an effective barrier to invasion of the body by pathogenic bacteria that may be in the colon. Catharsis is one way to disturb this mechanism and lift the barrier. McPherson took a series of 644 normal postpartem women and divided them into 2 groups. To one group he administered cathartics; the other he left alone. All members of the first group ran low grade fevers, which he rightly ascribed to disturbance of the intestinal defenses brought about by the catharsis, with entrance of pathogens into the blood stream.

A fact that is often overlooked is that the normal, formed feces offer a poor culture medium for the growth of bacteria. The normal stool of a typhoid carrier will not give much, if any, growth of typhoid bacilli on a suitable culture medium. But if the same patient is given a cathartic and the resulting loose watery stool is cultured, a luxuriant growth takes place.

Very few of the intestinal bacteria form soluble toxins, which is a point that is well borne in mind.

Bacterial digestion of protein is carried on in the small intestine and cecum. When this is excessive, harmful products such as histamine are formed. Absorption of these harmful agents is thought by some to be a factor in the production of auto-intoxication, so-called. It is even contended that absorption of these products leads to arteriosclerosis and other changes of senescence. The action of histamine on the blood vessels is known. The entire question of intestinal auto-intoxication is unsettled. That toxic absorption can occur is freely admitted, but how, when, and why it occurs, is unknown. Such intoxication occurs readily during the course of diarrheas.

The place of vegetables in the diet has been, is and perhaps always will be, a subject for heated argument. Man's colon is structurally more closely like that of the *carnivores* than of the *herbivores*. No conclusive evidence has been adduced to prove the presence of a ferment for the digestion of cellulose in man's intestinal tract. Cellulose does hasten the progress of all food through the gastro-intestinal tract, and hence interferes with digestion and absorption. Its presence also favors bacterial growth. These properties of cellulose-rich vegetables make them unsuitable for the diet of a patient suffering from colonic disease. The normal individual should not indulge in an excessive vegetable diet, either, because man is not equipped for their adequate digestion and, as just stated, they interfere with normal digestion.

The progress of colonic content is the result, mainly, of 3 or 4 mass peristaltic movements in 24 hours. The strongest stimulant to colonic movement is the entrance of food

into the stomach. This stimulates the gastro-ileal, and gastrocolic reflexes. The normal colonic content has within itself the stimulative properties necessary for normal colonic activity. When there exists a disease which can affect the colon directly or indirectly, the normal gradients of irritability are upset, and may become exaggerated, depressed, or reversed. The normal gradient of irritability of the colon, like that of the rest of the alimentary canal, is greater orad and diminishes as we go down the colon. The sigmoid is an exception to this, for at this point there is a sudden increase of the gradient; which accounts for the emptiness of that segment of gut so frequently found at necropsy; and it also explains the alarming symptoms of volvulus of this area.

Defecation is the result of a finely coördinated mechanism of both voluntary and involuntary muscles. When feces enter the ampulla of the rectum, the distention produced brings into consciousness the need for an evacuation. That it is distention of the ampulla and not the mere presence of feces which is the adequate stimulus to defecation has been proved many times by artificial distention of the ampulla of the rectum. Auto-intoxication produced by constipation is based on very little, if any, fact. As shown by Alvarez, the same symptoms that are present in some constipated individuals can be produced exactly by stuffing the rectal ampulla with cotton. Removal of the cotton promptly relieves the symptoms. If it were true that these symptoms, in the constipated person, were due to absorption of toxins, they could not be relieved immediately after evacuation of the bowels, because it takes some little time for toxins to be excreted from the body.

Where there is an injury to the lower segment of the spinal cord, below the lumbar region, the sensation of distention of the rectum is lost, and the need for defecation does not enter into consciousness, but defecation will occur at intervals because of the intact reflex arc. Even where the reflex arc is destroyed, the automaticity of the colon will bring fecal matter to the rectum at intervals. This type of person should not receive cathartics for inducing bowel movement, for this liquifies the feces and incontinence results. Enemas, rather, are indicated.

McCarrison has shown that health of the gastro-intestinal tract is dependent upon an adequate supply of vitamines. Their lack gives rise to pathologic changes throughout the canal. Colitis is induced by absence of the growth-vitamine; and the absence of vitamine C causes hemorrhagic and congestive lesions. These findings can be made use of in treating chronic diarrheas, with good results.

In bringing this paper to a close, it may be in place to mention something about atony of the bowel. It will be recalled by all who have had experience in examining large numbers of x-ray pictures of the colon, that the musculature has rarely, if ever, appeared to be anything but normal. This makes one begin to doubt the existence of so-called atonic constipation. It has been found, by animal experimentation, that the force with which the ileum delivers its content to the colon is sufficient to carry it on through the entire colon. Animals, in which all the musculature of the colon was removed, did not suffer from constipation.

PREVENTIVE MEDICINE FROM THE STANDPOINT OF THE INTERNIST; ITS VALUE FOR PUBLIC HEALTH*

Lewellys F. Barker, M.D.,
Emeritus Professor of Medicine, Johns Hopkins University,
Baltimore, Maryland

The invitation of your President, Dr. R. McKiernan, to me as an internist to address this ancient and honorable society upon "Preventive Medicine and Its Value for Public Health as Viewed from the Standpoint of Inner Medicine", I accepted willingly, because of my genuine interest in the topic and particularly, too, because of its timeliness, owing to the rapid changes that have recently been taking place in the field of medicine. Though

*(An Address delivered at the Annual Dinner of the Middlesex County Medical Society, in New Brunswick, December 21, 1932.)

medicine has never been static, the necessity for changes in medical practice and in medical organization, in order to keep pace, on the one hand, with advances in medical knowledge and medical skills, and, on the other, with the evolution of general social and economic conditions, has perhaps never seemed to be more imperative than now. Discussion of the relations of the medical profession to the public has entered upon a new phase during the present autumn, since announcement was made of the recommendations of the Committee on the Costs of Medical Care—after an intensive study (for 5 years) of the economic aspects of the prevention and care of illness. In the Committee itself, though there was unanimity with regard to many of the recommendations made, there were sharp differences of opinion as to certain measures suggested, with the result that a *strong minority report* accompanied the report submitted by *the majority*. That upon these matters there will be lively debates in the immediate future among medical practitioners, public health officers, sociologists and economists, there can, I think, be no doubt; and these debates are to be welcomed—since nothing is likely to clarify a situation more quickly than active discussion in which both sides of the controversy adduce their facts and formulate their arguments in favor of and against the opinions promulgated. With both sides desirous to do what is best and to be fair, on the one hand, to the rights of the public, and, on the other, to the legitimate interests of the medical profession; there should, in time, be but little difficulty in arriving at reasonable and equitable conclusions. Though there will, of course, always be some extremists in whom *passion will outweigh logic,* I, for one, have great confidence in the common sense of our people and in their ability and willingness, when all sides of a disputed question are thoroughly presented, to arrive at decisions that are, for the time being at least, expedient.

Preventive medicine is not a new thing; it was of early origin, as an examination of ancient records has shown. Its practice was begun, as might have been expected, by those who were actively engaged in the work of curative medicine; that is to say, by the physicians. It was natural, even in the infancy of civilization, for the healers of diseases to look for their causes; and, when they could not be sure of them, to speculate about them. Many of their observations were accurate, though many of their hypotheses were wrong. But, based sometimes upon fact, at other times upon fancy, those doctors of olden times recommended measures that they believed to be preventive of disease and suffering. By the time Greek civilization was in full flower, it was possible for Hippocrates to divide the causes of disease into an external group (such as those concerned with seasons, climates and other external conditions) and an internal group (such as those concerned with personal habits and dispositions). He recognized the great principle—that the body varies in disposition to attacks from without, and in powers of defensive reaction against such attacks. Disease was for him the evidence of a struggle between the body of a sick person and the disease cause. He not only taught the healing power of Nature, and advised doctors to copy her methods, but he urged also the cult of proper living—the importance of fresh air, pure water, sun-light, diet, exercise and good personal habits for the promotion of health, the prevention of disease, and the postponement of death.

With the revival of learning, interest in the knowledge of the Greeks was renewed, and such men of genius as Leonardo da Vinci, Vesalius, Harvey, Helmont and Sydenham introduced the experimental principle and improved the observational methods that quickly led to discoveries bearing upon the nature and origin of disease and upon its prevention. Later on, came the germ theory of the origin of infectious and contagious diseases, culminating in the researches of Louis Pasteur and of Robert Koch, by which the specific microorganisms of a great group of diseases were recognized and grown upon culture media. Still later, Laveran discovered the malarial plasmodium, and Manson and Ross studied the life history of the mosquito in relation to this parasite. The discovery of trypanosomes, of spirochetes, and of filtrable viruses, fol-

lowed in turn. The methods by which these bacteria and other parasites injured the body were investigated as well as the methods by which the body defended itself against their attacks. And thus developed the conceptions of toxins and antitoxins, of serotherapy and other forms of immunotherapy, of allergy, and of vaccines.

Along with these fundamental discoveries, practitioners of medicine and surgery were attempting to find ways and means of preventing abortions, miscarriages and still-births; children's diseases like malnutrition, dental caries, ophthalmia and rickets; and many diseases of adults, like infectious arthritis, the venereal diseases, and such degenerative disorders as arteriosclerosis, high blood pressure, and chronic Bright's disease. The importance of vitamins and of mineral salts for health was established; diseases like beri-beri, scurvy, and pellagra came under control. The surgeons developed antiseptic and aseptic methods of treating wounds. They practiced preventive medicine: by removing infected tonsils and adenoids, grumbling appendices, and infected gall-bladders; by injecting tetanus antitoxin in the treatment of contaminated wounds; by timely operations upon persons having phimosis, hernia, or a neoplasm; and, by corrective surgery on deformities.

It was no wonder that *prevention* (or prophylaxis) became *the true ideal of medicine.* Nor did it take long for the general public to realize that it was impossible for the medical profession unaided adequately to apply to prevention all the knowledge that it had gradually accumulated. Hence arose Public Health, or State Medicine, that applied preventive methods for protection of the community; the prevention of disease and its sequels in the individual was left, for the time, almost entirely to private practitioners of medicine. Very gradually, however, the State functions in preventive medicine underwent extension until, of late, many of those interested in the private practice of medicine have protested that the State is threatening the welfare of private practitioners by its ever-increasing encroachments upon their domains.

There was practically no objection made to the first phase of public health work in which the State undertook to solve the problems of sewerage, drainage, water supplies, disposal of refuse and adequate housing. Nor was there much protest against the activities of the State in the second phase. This second stage was entered upon about 50 years ago when health officials undertook to lessen the prevalence of acute communicable diseases by limiting the spread of infectious agents through the population. Since the beginning of this work ever-new methods have been applied—quarantine of the infected, isolation of germ carriers, disinfection of excreta, sterilization of water, and pasteurization of milk at times of epidemics, campaigns against insect carriers, and vaccinations and artificial immunizations of various sorts. Through such efforts it became possible greatly to reduce the incidence of smallpox, typhoid fever, cholera, bubonic plague, dysentery, diphtheria, scarlet fever, measles, malaria, typhus fever and yellow fever; though attempts to control the spread of diseases like influenza, pneumonia, infantile paralysis and epidemic encephalitis, have been less successful. During the past few decades, a third and entirely new phase of disease prevention work by public health authorities has been in evidence. I refer to the series of preventive measures that began to be applied in the fight against the spread of tuberculous infections. It had become obvious that the simple and more direct measures that were efficacious in preventing the spread of the acute communicable diseases, were wholly insufficient when it came to the prevention of an endemic communicable disease like tuberculosis, which ran a chronic course, was exceedingly prevalent among all classes, and was socially very destructive. It is largely to the credit of the voluntary anti-tuberculosis societies and of public health agencies in America, that effective methods in the campaign against tuberculosis were worked out in detail. These methods involved the establishment and maintenance of continuous inter-relations between health agencies and the people as a whole by means of public health clinics, public health nurses, and systematic

programs of popular education in health matters. Sanatoriums for the tuberculous, the tuberculosis nurse, public lectures upon the methods of preventing tuberculosis, and articles in the public press upon the subject—all of which were financed largely by agencies of public health—developed as a matter of course. Private practitioners of medicine cooperated enthusiastically with public health officials in the anti-tuberculosis campaign, scarcely realizing at the time, however, the implications, the broader logical and philosophic aspects, or the probable further evolution of the kind of public health work that was thus inaugurated.

Let us consider briefly what has happened since then. The movements have occurred so recently and so rapidly that many members of the medical profession scarcely realize how manifold and how extensive they have been.

First, came the activities of health officials in the public schools. The school physicians, attempting to prevent the spread of acute communicable diseases and tuberculosis among school children, soon found it desirable to examine each child on entrance to school, and to keep all children under their observation while in attendance at school. Among the children thus examined, many instances of faulty nutrition and of physical defects of various sorts (nasopharyngeal, visual, auditory, orthopedic) were discovered and were reported by school nurses to the parents with recommendations for correction by family physicians or, when necessary for poorer families, by the doctors at public clinics.

In the second place, programs for the hygiene of infancy began to be developed. It was found that among the poor, the care and feeding of infants was often very faulty; partly owing to poverty, partly owing to ignorance. Public milk stations that provided milk of the proper quality and formula suited to the age, and infant welfare stations for the supervision of infants brought by their mothers at regular intervals, made their appearance in response to obvious hygienic needs; and, in some instances, visiting nurses were sent by such welfare stations into the homes to give aid and advice to the mothers of ailing infants.

In the third place, it became recognized that—if American public school children were to develop satisfactorily—they must not only be supervised in early infancy, and after entrance to the schools, but also during the intervening period. Accordingly, the next step was to provide for an extension of the system of medical and nursing supervision so as to cover the whole period of the first 6 years of life.

In the fourth place, shocked by the number of still-born children and by the heavy mortality among children immediately after birth, health departments and welfare organizations organized, in some places, a delivery service for mothers, and a supervisory service for the period of pregnancy, in the families of the poor; in the belief that neo-natal and pre-natal care can also be of great service in preventing infant mortality and in giving the oncoming generation a better start.

In the fifth place, the good effects that followed these methods of supervision during infancy and childhood were so impressive that they spurred the men and women interested in preventive medicine to make provision also for regular medical supervision of adolescence and even of adulthood. Health services began to be developed in colleges and universities, public clinics for the diagnosis and treatment of venereal diseases were endowed, the movement for mental hygiene got under way, industries instituted health services for employees, and among the general public the tendency to undergo regular periodic health examinations by private physicians or by Life Extension Institutes grew apace.

This evolution in our time of the methods of prevention of disease has been one of the most striking features of contemporary civilization. In an admirable survey of the process, made some 5 years ago, Professor A. W. Freeman, of the School of Hygiene and Public Health, of the Johns Hopkins University, gave it as his opinion that "the public health of the future will be based on a system of continuous medical supervision for health, including every citizen, whatever his degree or station, and covering the entire period from conception to final dissolution". He went even further and suggested "should that eugenics became a program instead of an ideal, the mo-

ment of conception will be too late for the proper initiation of this plan of supervision".

This bird's-eye view of the evolution of preventive medicine reveals very clearly the trend of events and the ever-increasing efforts to diminish the incidence of disease by timely application of the knowledge that medical men have amassed. It is also plain that preventive activities are becoming ever more closely linked with curative activities, and, of late, we have frequently heard it suggested that these 2 types of work should be definitely combined and delegated for performance to a unified organization of medical men; in other words, there are some persons who would not only combine preventive work for the community with preventive work for the individual, but would also fuse the function of curing disease with the function of preventing disease. The arguments in favor of such a plan are based largely upon our defective economic organization, which entails the making of adequate medical care for a large part of the population a matter of charity rather than a matter of right and justice; a situation that is embarrassing to the social conscience of our people. That the rich and the well-to-do can secure the best medical services goes without saying. It is also true that the very poor people can, through dispensaries and the free wards of hospitals, be fairly well provided for when they are ill. But there is a great intermediate class—neither rich nor poor—that fares less well as regards both curative and preventive medical services, despite the fact that members of the medical profession are always ready to do their utmost to provide such services at a cost that will be no hardship to the recipients.

It is this total situation that has been carefully studied during the past 5 years by a Committee on the Costs of Medical Care; with Dr. Ray Lyman Wilbur, as Chairman; Dr. C.-E. A. Winslow, as Head of the Executive Committee; and Mr. H. H. Moore, as Director of Studies. The Committee includes approximately 50 members who represent: the private practice of medicine; public health work, institutional work; sociologic and economic interests; and the public at large. Funds were supplied by 8 of the great "Foundations" for the prosecution of research by a group of experts who have concluded more than 25 separate investigations; the results of which have been published in separate monographs. The final report of the Committee, together with *recommendations,* was made public this month and is now available in a volume entitled "Medical Care for the American People".

The total annual expenditure at present for medical services of all kinds in the United States (including services purchased indirectly through taxes and other community funds), is approximately $3,500,000,000 or $30 *per capita;* as compared with nearly $6,000,000,000 spent for tobacco, toilet articles and recreation; and with $9,500,000,000 spent for the use of automobiles and other modes of travel. Unfortunately, of the amount spent for medical services, $125,000,000 go to osteopaths, chiropractors, naturopaths and faith healers, and $360,000,000 are spent for "patent medicines". Despite these sums and certain other wastes, the total annual amount spent for medical service is believed to be reasonable. But the costs of medical care in any one year fall very unevenly upon different families in the same income-and-population groups. When serious illnesses occur, requiring hospitalization, the costs entailed may be disastrous for families with moderate incomes, even though the incomes of medical practitioners and nurses may not be too high. It has been estimated that if medical services could be organized economically and sold to representative groups of the population, all needed medical care of the kind ordinarily purchased could, at least in cities, be provided at a cost, excluding capital charges, of from $20 to $40 *per capita per annum.* This estimate includes the cost of the services of physicians, dentists, and other personnel, as well as of provision of hospitalization, laboratory and x-ray services, drugs and other items. The problems would, therefore, seem to consist of the devising of plans: (1) for economic organization of the services; and (2) for distributing the burdens of the medical expenses so that they will be no hardship to the recipients of

medical care; while at the same time those who provide the care are adequately compensated.

Can such economic organization of medical services, and such distribution of the costs of medical care, be satisfactorily brought about in a country like ours, with its existing social and economic systems? Some say "No"; others say "Yes". The Committee on the Costs of Medical Care has studied these problems, and has proposed solutions of them, intensively.

In order that any medical program may be sound, effective and satisfactory, at least 6 basic provisions seem to be essential:

(1) The quality of the medical services must be safeguarded, and the necessary personal relations between patients and physician must be maintained.

(2) The true needs of the people for curative and preventive services must be met.

(3) The costs must not exceed amounts that can and will be defrayed by individuals or groups without undue hardship.

(4) The program must include not only individual and family care but also adequate support of public health measures.

(5) Provisions must be made for assisting and guiding patients in the selection of competent practitioners and of suitable facilities for medical care.

(6) The individuals and agencies furnishing such care must be adequately remunerated.

A majority group of the Committee is of the opinion that these 6 essentials could be provided for, if the following recommendations could be followed:

(1) That medical services, both curative and preventive, be furnished largely by groups of physicians, dentists, nurses, pharmacists and other personnel (organized preferably around a hospital to create a "community medical center"), for rendering complete home, office and hospital care, maintaining high standards and preserving the personal relation between patient and physician.

(2) That basic public health services be made available to the entire population according to its needs.

(3) That the costs of medical care be placed on a group-payment basis, through the use of insurance, through the use of taxation, or through the use of both insurance and taxation; with the proviso, however, that the continuation of medical service on an individual-fee basis for those who prefer the present method, should not be precluded.

(4) That agencies be formed in every state and local community for the study, evaluations and coördination of medical services, special attention being paid to the coördination of rural with urban services.

(5) That certain changes be made in the training of physicians, dentists, pharmacists, nurses, administrators, and other personnel, to correspond to the needs of the proposed organization of medical services.

These recommendations are built upon existing institutions and agencies, which it is proposed shall gradually undergo further evolution toward the objectives visualized in order to supply satisfactory medical care to a much larger number of people than that receiving such care now. Each local community would have to determine through careful study what kind of program is best adapted to its own particular needs. The leadership should be assumed by some coördinating agency; perhaps by a State or County Medical Society; perhaps by a Health Department; or, perhaps by some newly created agency. Success would be impossible without the cooperation of the professional groups concerned, and, certainly, the lay groups participating would have to agree that the standards and the methods of work will be controlled by the professional groups themselves. The mistakes of Europe should be known and avoided by those who construct the programs.

An important *minority group* in the Committee, while in accord with the majority in many of their conclusions and recommendations, particularly with regard to the strengthening of public health services, certain basic educational improvements, and better coördination of medical services, is in sharp disagreement with certain of the recommendations; especially that for the wholesale provision of medical services through the organization of community medical centers, as well as that for

group payment for medical services through insurance (either voluntary or compulsory).

The *minority group* recommends:

(1) That government competition in the practice of medicine be discontinued and that governmental activities be restricted: (a) to the care of the indigent, and of those patients with diseases that can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, etc.; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases, except in case of tuberculosis and neuropsychiatric diseases.

(2) That government care of the indigent be expanded in order that the medical profession may be relieved of the burden.

(3) That measures for the coördination and control of medical services be put into effect in the immediate future through committees of medical, dental and pharmaceutic societies and hospital associations.

(4) That united attempts be made to restore the general practitioner to the central place in medical practice.

(5) That the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed.

(6) That careful trial be given to methods that can be rightly fitted into our present institutions and agencies without interfering with the fundamentals of medical practice; among such methods, a thorough trial of the County Society Plan for furnishing complete medical care, is especially advised—because it is an attempt to distribute the costs of medical care, by *utilizing the good* in insurance plans, while avoiding their dangers and evils.

One member of the Committee presented a separate statement, in which, after a review of the development of existing economic conditions in medicine, he expressed the belief that the ideals of medicine as a public service now demand that the aims and the arrangements for profit-making shall be completely eliminated from the practice of the art. In his opinion, a medical service, to be adequate, must comprehend the whole population; for, maintenance of the "common health" is now a public necessity as well as a social duty. The facilities for health should be just as freely available for all who need them as are the schools. He further suggested that the scheme called "compulsory health insurance" is the very minimum that the Committee should have recommended, and gave his reasons for this view and his ideas of organization for the purpose, including the invoking of the authority of the State to make membership compulsory and to insure the collection of personal assessments. The practical course, he believed, is to set up the system and to allow the usages essential to its success to grow up about it; for it seemed to him that the haphazard system of private medical enterprise is a luxury that cannot longer be afforded and that the maintenance of the physical welfare of the people must be made a public function.

But I have, I fear, already kept you too long. I desired, however, to make clear to you the changing conditions in medicine, as well as to present to you, in outline, some of the plans for the future that are now under consideration. If they have excited your interest, and especially if they lead some of you personally to consider the problems by which we are confronted, and the possible solutions of those problems, I shall be glad.

Life is mostly froth and bubble;
Two things stand like stone:
Kindness in another's trouble,
Courage in our own.

—The Kalends.

BOOKS ON NATIONAL HEALTH INSURANCE

As some of our readers may wish to delve deeper into the literature of National Health Insurance, while giving consideration to the Report of the Committee on the Costs of Medical Care—an abstract of which is presented in this Journal—we offer the following list of books from among which they may select to meet their needs.

(1) The Statutes, Regulations and Orders Relating to National Health Insurance in Great Britain.

(2) Medical Insurance Practice, by R. W. Harris, formerly Assistant Secretary in the Ministry of Health, and Leonard S. Sack, of the Middle Temple, Barrister-at-Law; (an interpretation of and reliable guide to the British law by the men who put it into operation).

(3) Annual Reports of the Chief Medical Officer, Ministry of Health.

(4) Proposal for Extension of Law (submitted by the British Medical Association in 1930; still pending in Parliament because of *depression*).

(5) Medicine in the British Isles, Sir D'Arcy Power (1930, published by Hoeber).

(6) Medical Education in Europe (by a Commission, of which Dr. Rappleye was Director).

(7) Sickness Insurance in Europe—Rappleye.

(8) Prevention and Treatment of Disease (3 volumes)—Sir Arthur Newsholme.

(9) Medicine and the State—A Summary (Newsholme's fourth volume, into which he has condensed the others).

(10) National Health Insurance in France. (Published by French Government.)

(11) National Health Insurance in British Columbia. (By Govt. of Province.)

(12) National Health Insurance in Alberta. (By Govt. of Province.)

(13) The Doctor's Mission, Dr. Erwin Liek (concerning health insurance in Germany, but the Author's prejudices deprive it of the value it should have).

(14) White House Child Welfare Conference (often called the Hoover Conference).

(15) New Jersey (Larson) Conference (published by N. J. Social Service workers).

(16) Health Work in Soviet Russia—Miss Haines (a Trained Nurse, of Moorestown, N. J.).

(17) Purchase of Medical Care—Pierce Williams.

(18) British Medical Association's Proposals for General Medical Service for the Nation. (Sale—B. M. A.)

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

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DELAYED ISSUANCE OF THE JANUARY JOURNAL

The Editor trusts he will be forgiven for the unusually late date of distribution of this Journal, upon the grounds that the delay resulted from his endeavor to provide you with something *better* than usual. Material for the January Journal was in the hands of the printer on time, and much of it was in type when, suddenly, a situation arose which made it seem wise to change publication plans. After due deliberation, it was decided to hold over until February such of the January material as was not urgently demanding publication, and to give all available space to an economic problem of the utmost importance to every member of the medical profession. Whether the decision was a wise one will appear later. This note is merely an explanation of *how* and *why* the delay was occasioned.

REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

Probably most of our readers know that the National Committee on the Costs of Medical Care concluded its investigations, and finished its labors with a public presentation of its final report at the New York Academy of Medicine, on November 29, 1932. The event was not unexpected and there existed a considerable degree of curiosity concerning the awaited report, in consequence of rumors that the Committee was "split" into factions.

As generally happens, the situation was not so bad but that it might have been worse. Differences of opinion had come to the surface, and several members of the Committee found acceptance of the finished report impossible and declined to affix their signatures. The entire Committee consisted of 48 members and, as we understand the situation, the Dissenters numbered 13. But, the Dissenters were not all of one mind, so we have: the regular Committee Report (probably hereafter to be known as the *Majority Report*), signed by 35 members; a *Minority Report*, signed by 8 physicians and 1 layman; a second Dissenting Report by 2 dentists; and, 2 Statements expressing the personal opinions of 2 members.

This Committee on the Costs of Medical Care, as finally organized, comprised 48 members representing somewhat varied interests and, in consequence, was classified in 5 groups, as follows: (1) *Private Practice*—(17): Lewellys F. Barker, M.D.; Walter P. Bowers, M.D.; A. C. Christie, M.D.; William Darrach, M.D.; George E. Follansbee, M.D.; M. L. Harris, M.D.; J. Shelton Horsley, M.D.; Kirby S. Howlett, M.D.; Arthur C. Morgan, M.D.; Herbert E. Phillips, D.D.S.; Stewart R. Roberts, M.D.; C. E. Rudolph, D.D.S.; Richard M. Smith, M.D.; Walter R. Steiner, M.D.; N. B. Van Etten, M. D.; Robert Wilson, M.D.; Rollin T. Woodyatt, M.D. (2)

Institutions and Special Interests—(10): W. Irving Clark, M.D.; Louis I. Dublin, PH.D.; Elizabeth Fox, R.N.; Ambrose Hunsberger, Phar.M.; Alfred Owre, D.M.D., M.D.; W. S. Rankin, M.D.; Mary M. Roberts, R.N.; Alphonse M. Schwitalla, PH.D.; Winford H. Smith, M.D.; Olin West, M.D. (3) *Public Health*—(6): George H. Bigelow, M.D.; Herman N. Bundesen, M.D.; Haven Emerson, M.D.; John Sundwall, M.D.; Edgar Sydenstricker; C.-E. A. Winslow, Dr.PH. (4) *Social Sciences*—(6): Michael M. Davis, PH.D.; William T. Foster, PH.D.; Walton H. Hamilton, PH.D.; Wesley C. Mitchell, PH.D.; William F. Ogburn, PH.D.; Henry C. Taylor, PH.D. (5) *The Public*—(9): Winthrop W. Aldrich; Morris L. Cooke, D.SC.; Mrs. William Kinnicutt Draper; Homer Folks, LL.D.; John P. Frey; Mrs. Walter McNab Miller; William J. Schieffelin, PH.D.; Amelia Sears; Ray Lyman Wilbur.

The *Majority Report* was signed by 35 members, among whom were 16 physicians. A *Minority Report* was then prepared and signed by 8 physicians and 1 layman—a clergyman; and, of these 8 physicians, 7 were from the *private practice group* and 1 from the group denominated as *institutions and special interests* (this last one being Dr. Olin West, Secretary of the American Medical Association now, but formerly a private practitioner). An analysis of the 16 physician-votes supporting the *Majority Report* shows that 8 were, in that instance also, from the *private practice group;* and at least 5 out of the remaining 8 are, or have been, engaged in private practice.

The 8 *Minority Report* physicians are: Drs. A. C. Christie; George E. Follansbee; M. L. Harris; Kirby S. Howlett; A. C. Morgan; N. B. Van Etten; Olin West; and Robert Wilson.

The *Final Committee Report*—including the *Minority Report* and the views held by the other Dissenters—has now been issued in book form under the title of "Medical Care for the American People", and is on sale at $1.60 per copy. It seemed to us highly desirable that every member of the Medical Society of New Jersey should have the opportunity to become familiar with all the essentials of the Committee Report; not merely the conclusions, but the findings and studies upon which the conclusions had been based. That every member would purchase the book was rather too much to expect. The Society could not afford to supply copies to all members, even if they could be purchased at a wholesale price. So it was that we decided to use the Journal for distribution of the information; which could be done without extra expense to members, individually or collectively.

A short abstract, put out from A. M. A. headquarters in Chicago, did not seem to cover our needs, so we had to make *a more liberal abstract.* We have italicized some words—not so treated in the original—but did so only *for emphasis or to clarify a statement.*

In addition to our abstract of the Committee Report, we are giving you: (1) the stenographic report of the Tristate Medical Conference, held December 10, 1932, which dealt with this same problem; (2) the Addresses delivered by Drs. Barker and Van Etten on the occasion of making the Report public; and (3) a paper read by Dr. Barker, at the December meeting of the Middlesex County Medical Society.

We have, throughout our preparation of these documents, carefully avoided any expression or indication of personal opinion. Our object has been to supply you with all available important facts.

A statement has recently been made, and from several different sources, that our profession needs at this particular juncture, as *leaders,* men who have especially studied and are familiar with the details of these problems. This Editor does *not* consider himself sufficienty competent to be designated a leader. But, even if he did, he would still feel that he should not at present express an opinion or offer advice—beyond the suggestion that all physicians should give serious thought to this Report. An Editor of an independent, privately owned medical journal would be at liberty to speak, but Editor of an *organization journal* must hold his peace, because it is for the organization to determine its policy with regard to such matters.

Special Article

THE FINAL REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

(This "Special Article" is a liberal abstract of the "Report" made from an advance copy, in the form of "galley proof", for this Journal. In a few instances, italics have been used to direct attention to important passages or for emphasis of one or a few words; otherwise, the language is that of the original report.—Ed.)

By Ray Lyman Wilbur, M.D.

Introduction

Pain, sickness, and bereavement have shadowed mankind throughout the ages; today there is a vast amount of unnecessary sickness and many thousands of unnecessary deaths. Each year, more than 100,000 babies die during the first year of life, many of them needlessly. Of the many thousands of victims of tuberculosis, 88,000 died in 1930 alone. Syphilis and gonorrhea destroy fertility, deform babies and wreck homes. The death rates for cancer, diseases of the heart, and diabetes are rising. A large proportion of the people, young and old, are handicapped by one or more defects—particularly decayed teeth, diseased tonsils, defective vision, partial deafness—and thousands are rendered inefficient for their various occupations because of common colds, constipation, headaches, rheumatism, and other minor ailments.

Medical science has made marvelous advances during the past 50 years, but we have the knowledge, the technic, the equipment, the institutions, and the trained personnel to make even greater advances during the next 50 years. We know how to do many things which we fail to do or do in an incomplete and often most unsatisfactory manner. As a result of our failure to utilize fully the results of scientific research, the people are not getting the service which they need—first, because in many cases its cost is beyond their reach, and second, because in many parts of the country it is not available. Furthermore, various practitioners of medicine are being placed in an increasingly difficult position—in respect to income and facilities with which to work.

At a conference in Washington, D. C., May 17, 1927 (at the time of the Annual Meeting of the American Medical Association), which was attended by some 60 representative physicians, health officers, social scientists and representatives of the public, the nucleus of the Committee on the Costs of Medical Care was created, and an Executive Committee was appointed. A Director of Study was employed to propose a program of research for consideration by the Executive Committee and to engage the necessary personnel. The Committee, for most of the 5-year period, has consisted of 50 members representing the fields of private practice, public health, medical institutions and special interests, the social sciences, and the general public. The Committee has met regularly twice a year; and as researches have been completed, it has studied the data thus made available. The Executive Committee, under the efficient leadership of its Chairman, has met monthly throughout the 5 years, except during the summer months. It has had general administrative supervision over the Committee's work and has examined reports on researches before they were submitted to the General Committee; which Committee has published not only complete reports of its studies which were of special interest to those professionally engaged in the general field of medicine, but it has issued also a *series of abstracts,* distributed without cost to various interested persons.

The work of the Committee would not have been possible had it not been for the generous support of *8 Foundations,* which have been helpful in providing the necessary funds; 2 of them giving special assistance in emergencies when the need for money was pressing. The Carnegie Corporation, the Josiah Macy, Jr., Foundation, the Milbank Memorial Fund, the New York Foundation, the Rockefeller Foundation, the Julius Rosenwald Fund, the Russell Sage Foundation, and the Twentieth Century Fund, provided the financial support necessary for the Committee's own extensive

5-year program. The Social Science Research Council and the Vermont Commission on Country Life each made a grant for a special study.

The American Medical Association, the American Dental Association, the Metropolitan Life Insurance Company, the National Bureau of Economic Research, and the National Tuberculosis Association, conducted supplementary studies of great value to the Committee's program, and the United States Public Health Service was especially helpful in analyzing an immense amount of statistical data on the incidence and cost of sickness among families.

In the course of its research, the Committee has encountered a number of questions which need further attention. Studies on several of such problems have been outlined, but work on them has not been inaugurated because of a lack of time and funds. It is hoped that when this Committee goes out of existence January 1, 1933, some other organization, formed for the purpose of promoting and coordinating further research in the field of medical economics, may consider the desirability of providing for these particular studies. It is hoped, both by Committee members and other interested persons, that a continuing organization may immediately be formed to promote experimentation and demonstrations in local communities along lines proposed in the *Committee's recommendations.*

With the present volume, the Committee presents its report of recommendations. It has labored during the past 2-3 years to discover the implications of the facts revealed by the various studies. The *recommendations* in the present report are based upon the data revealed in the 26 major reports on fact-finding studies, in its series of Miscellaneous Contributions, in the reports of collaborating agencies, and in a large number of documents issued by other organizations. A tentative draft of recommendations, as formulated in May, 1932, was submitted to a small group of competent professional advisers who, at the earnest request of the Committee, subjected it to frank and thorough-going criticism.

Early in the Committee's work it was expected that there would be one or more minority reports, and the Committee, therefore, makes no apology for the fact that its 48 members have not reached a unanimous agreement on a series of recommendations. When the Committee was organized, an effort was deliberately made to secure as members *persons representing all points of view* on the problems under consideration. There are 2 important results of this policy: (1) All interests and points of view have been adequately considered in formulation of the Committee's recommendations; (2) there has been a small minority group which, not able conscientiously to subscribe to the views of the majority, has submitted a minority report; and 4 members have prepared personal dissenting statements. It should be clearly pointed out that the majority group is responsible only for the contents of the basic report, and the minority group is responsible only for the contents of its report.

The quality of medical care is an index of a civilization. When in earlier centuries the entire time and energy of a people were consumed in providing food, clothing and shelter, little was left for care of the sick and disabled. As the margin between production and the needs of mere subsistence expanded the preservation of health was one of the first needs to receive attention. Today, in American civilization, health occupies a high place among accepted social values. As we emerge from the present depression and build up a surplus of income not necessary for mere subsistence, we will do well to realize that we can invest this surplus in no better way than in the preservation of health.

Our physical and mental health is perhaps the nation's greatest asset. It behooves each community, therefore, to consider what plan will most effectively promote the health of its citizens. To each and every community in the United States which desires to provide better medical care and increased health for all of its people, the Committee offers these recommendations. The report affords, for the first time, a scientific basis on which the people of every locality can attack the perplexing problem of providing adequate medical care

for all persons at costs within their means, and it is hoped that the report may thus aid materially in bringing greater health, efficiency, and happiness to all the people.

List of Members of the Committee on the Costs of Medical Care as of October 31, 1932, and their representative relationships to the profession of medicine. *Private Practice*: Lewellys F. Barker, M.D.; Walter P. Bowers, M.D.; *A. C. Christie, M.D.; *George E. Follansbee, M.D.; *M. L. Harris, M.D.; J. Shelton Horsley, M.D.; *Kirby S. Howlett, M.D.; *Arthur C. Morgan, M.D.; *Herbert E. Phillips, D.D.S.; Stewart R. Roberts, M.D.;* C. E. Rudolph, D.D.S.; Richard M. Smith, M.D.; Walter R. Steiner, M.D.; *N. B. Van Etten, M.D.; *Robert Wilson, M.D.; Rollin T. Woodyatt, M.D. *Institutions and Special Interests*: W. Irving Clark, M.D.; William Darrach, M.D.; Louis I. Dublin, Ph. D.; Elizabeth Fox, R.N.; Ambrose Hunsberger, Phar.M.; Alfred Owre, D.M.D., M.D.; W. S. Rankin, M.D.; Mary M. Roberts, R.N.; Alphonse M. Schwitalla, Ph.D.; Winford H. Smith, M.D.; *Olin West, M.D. *Public Health*: George H. Bigelow, M.D.; Herman N. Bundesen, M.D.; Haven Emerson, M.D.; John Sundwall, M.D.; *Edgar Sydenstricker; C.-E. A. Winslow, Dr. Ph. *Social Sciences*: Michael M. Davis, Ph.D.; William T. Foster, Ph.D.; *Walton H. Hamilton, Ph.D.; Wesley C. Mitchell, Ph.D.; William F. Ogburn, Ph. D.; Henry C. Taylor, Ph.D. *The Public*: Winthrop W. Aldrich; Morris L. Cooke, D.Sc.; Mrs. William Kinnicutt Draper; Homer Folks, LL.D.; John P. Frey; Mrs. Walter McNab Miller; William J. Schieffelin, Ph.D.; Amelia Sears; Ray Lyman Wilbur, M.D.

CHAPTER I

The Present Status of Medical Care

The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate, either in quantity or quality, and the costs of service are unequally distributed. The result is: a tremendous amount of preventable physical pain and mental anguish; needless deaths; economic inefficiency; and social waste. Furthermore, these conditions are largely unnecessary. The people of these United States certainly have the economic resources, the organizing ability, and the technical experience to solve this problem; but, in their understanding of the care of the human body, and of public health, a very large percentage of them has not kept pace with the growth of scientific medicine. There is, and will continue to be, a lag between scientific advance and popular understanding and appreciation. The possibility of providing medical care for all of them, depends in part upon education; which is frequently a pre-requisite to change. The most satisfactory solution of the problem—of providing adequate scientific medical service for every person according to his needs—will be found only when the leaders, of the people and of the professions, join hands on a basis of mutual understanding, respect, and confidence.

Professional and Economic Status of Medicine

As a profession, medicine has gone forward with strides during the past century, and especially during the past 25 years. Its progress in understanding the human body, and in perfecting technics and instruments, is almost unique in the history of civilization. Within the span of a single life-time, the wide-spread utilization of anesthesia, aseptic surgery, bacteriology, physiology, and radiography, has revolutionized the practice of medicine. Even during the past decade, medicine's advance in the unending warfare against sickness is little short of miraculous; and, physicians and other men of science have displayed an unparalleled generosity in making available to their colleagues, and thus to all mankind, the results of their research and inventive genius.

As an economic activity, however, medicine has made much less phenomenal progress. The predominant economic institution in medical practice today—private individual practice—dates back to ancient times. Under this system, medical services are now so provided that many persons either cannot and do not receive

An asterisk (*) indicates that the member supports one of the minority reports.

the care they need, or are heavily burdened by its costs. At the same time, many of the practitioners and the agencies which provide medical service are inadequately occupied and poorly remunerated. A barrier—in large part economic—stands between practitioners who are able and eager to serve, and patients who need their service but are unable or unwilling to pay for it.

Nearly 1,100,000 persons in the United States devote all or a large part of their time to providing medical service and from it derive their livelihood; about ½ being private practitioners.

PERSONNEL ENGAGED IN THE PROVISION OF MEDICAL CARE AND THE SALE OF MEDICAL COMMODITIES

Personnel	Private Practice	Medical Institutions or Sale of Commodities
Physicians	121,000	21,000
Dentists	56,800	5,600
Graduate nurses	110,000	70,000
Student nurses		80,000
Public health and industrial nurses		16,000
Practical nurses	150,000	
Midwives	47,000	
Chiropodists	5,000	
Optometrists	20,000	
Osteopaths	7,650	
Chiropractors	16,000	
Naturopaths	2,500	
Religious healers	10,000	
Pharmacists		140,000
Lay personnel in hospitals, clinics and public health agencies		204,000
	545,950	536,600
Grand total		1,082,550

Hospital beds under government control in 1931 constituted 66% of all hospital beds in this country, and 73% of all patient-days of service were rendered by these governmental institutions. Nearly 8000 clinics and outpatient departments of hospitals, about 60,000 drug stores, and a small number of private laboratories and other medical institutions are available. Every state and large city, many of the smaller cities, and a few rural areas, are now served by health departments with full-time personnel. These are the facilities on which the American people rely for prevention and cure of disease.

These facilities, however, are not distributed primarily according to needs, but rather according to real or supposed ability of patients to pay for service. As a result, many communities are under-supplied with practitioners, hospitals, and other facilities, while others have a surplus. For example, in 1929 there was 1 physician to every 1431 persons in South Carolina, as contrasted with 1 to every 484 in California and 1 to every 583 in New York State. In 1928, of the 3072 counties in the United States, only 1765 had hospitals for general community use. Wisconsin had 1 bed for community use to each 154 people, while South Carolina had 1 to each 749 persons. There is also a maldistribution by type. For example, approximately 45% of the physicians of the country have completely or partially limited their practice to a specialty; although, apparently, the needs of the people could be met adequately if not more than 18% of physicians were specialists.

Medical service needed and received. In a nation-wide survey of illnesses and costs of medical service among 9000 white families, the Committee found that there was substantially the same incidence of illness per family or per individual in the various broad income groups. Families with incomes under $1200 or $2000, however, receive far less medical service than those with incomes of $5000 to $10,000 and over.

It is evident that the 2 or 3 lowest income groups receive far less of nearly every service—care from physicians and dentists, hospitalization, eye care, health examinations, immunizations, special nursing, maternity care, and x-ray and other laboratory service—than the groups with the highest incomes. The group with the lowest amount of service (which was not in every case the group with the lowest income) received only 50% as many days of hospitalization, and 42% as many calls from physicians, as the group with the highest amount of service (in every instance the latter is the group with the highest income). Only 1/5 as many persons in the lowest income group receive any dental attention. The families with incomes of $1200 to $12,000 receive even less hospitalization services than do the families with incomes under $1200.

Some persons may object, however, that the higher income groups *receive more service than they need,* because they enjoy the luxury of being attended by physicians and nurses, or are being kept under treatment to serve the economic interest of the practitioners. While occasional instances of that sort are known to everyone; a comparison of the services received by those in the high-income groups with the standards for good medical care published by the Committee, show that *even among the highest income group insufficient care is the rule.* The only services which this group uses more than appears to be necessary are—special nursing of hospital patients and the hospitalization of surgical patients. For all the other services listed, including even prenatal and post-natal calls to maternity patients and immunizations and health examinations, the *wealthy families receive less service than these conservative standards require.* The most significant numerical measures of the adequacy of services are the number of home, office, and clinic calls by physicians, and the per capita number of days of hospitalization. Of these items, the well-to-do patients received 84% and 88%, respectively, of the "standard" amounts.

The groups with small incomes obtain far less service. *In spite of the large volume of free work done by hospitals, health departments, and individual practitioners,* and in spite of the sliding scale of charges, it appears that each year *nearly ½ the individuals in the lowest income group receive no professional medical or dental attention of any kind, curative or preventive.*

Use of Preventive Medical Services

Although many practitioners suffer enforced idleness, the American people need far more of the medical services which could be provided on the basis of present knowledge and facilities. This is particularly true of preventive services. For example, in any single year less than 7% of the population have a complete or partial physical examination, and less than 5% are immunized against diphtheria or some other disease. In a special survey of pre-school children, the White House Conference learned that only 51% of city children, and only 37% of rural children, have had health examinations prior to their sixth birthday; that only 13% of children in both urban and rural districts have received a dental health examination by their sixth year; that only 22% of city children and only 7% of rural children have been vaccinated by the time they are 6; and that only 21% of urban and only 18% of rural children have been immunized against diphtheria.

Several factors cause this limited utilization of preventive medical services: (1) Most laymen hesitate to seek medical care except when driven by pain or discomfort; (2) payment on a fee-for-service basis is a greater economic deterrent to the utilization of preventive services than of curative work; (3) in some rural areas, medical practitioners and other facilities are actually unavailable, and, even in cities where there is an ample supply, the training of many practitioners and the avowed scope of many hospitals and clinics cause them to pay little attention to the preventive aspects of service; (4) the physician who is aware of a patient's needs for preventive work may refrain from urging it because he does not wish to appear as soliciting work.

Present Total Costs of Medical Service

Medical care has always been and will undoubtedly remain essentially a personal service. Contrary to the trend in most other human activities, an increased division of labor (specialization) and a larger capital investment in buildings and equipment have, in general, tended to increase costs rather than decrease them.

The people of the United States, in 1929, spent $3,647,000,000 for all forms of medical service, including those services purchased indirectly through taxes and other community funds. This is approximately *$30 per capita, per annum,* and in 1929 constituted about 4% of the money income of the country; not excessive for the population *as a whole* in view of the national expenditures in 1929 for tobacco, toilet articles, and recreation ($5,807,000,000), for automobile use and other travel ($9,475,000,000). In fact, it is probable that, with a better distribution of the burden and with the growth of national income which is

TOTAL EXPENDITURES FOR MEDICAL CARE

(All figures in thousands of dollars)

Service	Total	Patients	Governments	Philanthropy	Industry
Physicians in private practice	$1,090,000	$1,040,000			$50,000
Dentists in private practice	445,000	445,000			
Secondary and sectarian practitioners	193,000	193,000			
Graduate nurses, private duty	142,000	142,000			
Practical nurses, private duty	60,000	60,000			
Hospitals: operating expenses	656,000	278,000	$300,000	$ 54,000	24,000
Hospitals: new construction	200,000		100,000	100,000	
Public health	121,000		93,500	27,500	
Private laboratories	3,000	3,000			
Orthopedic and other supplies	2,000	2,000			
Glasses	50,000	50,000			
Drugs	665,000	665,000			
Organized medical services	29,000	7,790	16,000	210	5,000
Total	$3,656,000	$2,885,790	$509,500	$181,710	$79,000

probable in the next 2 or 3 decades, far larger amounts will be spent advantageously and without hardship.

Without an increase in the national income, however, larger returns may be obtained by a re-direction of part of the nation's present expenditures. Of the $3,647,000,000 spent annually for medical service, $125,000,000 is spent for the services of osteopaths, chiropractors, naturopaths and allied groups, and faith healers, and $360,000,000 for "patent medicines". Much of the former sum and practically all of the latter are wasted. Possibly even greater sums are wasted through inferior services rendered by some licensed physicians and dentists, and through the inadequate use of general hospitals and of the time and equipment of practitioners. In spite of these wastes, the total amount of the national expenditure for medical service is, in the Committee's opinion, reasonable.

Distribution of Costs

The primary reason why the costs of medical care cause complaints is that the costs are uneven and unpredictable. The disparity for a large majority of families between *average* incomes and *actual* incomes is matched by an equal or greater disparity between average and actual costs of medical care.

The individual family derives no comfort from the knowledge that the *average* cost of medical care is not excessive for families with the *average* income. If a family lays aside for medical costs 4% of its annual income (say $110), it may spend only $10 or it may spend $800. The budgeting of family income, which has been encouraged of late years and has been greatly facilitated by the use of installment payments, may assist families in planning for expenditures which can be determined in advance. But the unpredictable nature of sickness, and the wide range of professional charges for nominally similar services, render budgeting for medical care on an individual family basis impractical. On the present fee-for-service basis, it is impossible, for 99% of families, to set aside any reasonable sum of money with positive assurance that such sum will purchase all needed medical care.

Professional and Institutional Incomes

Medical costs which are too high for many families do not necessarily mean high incomes for practitioners. Although it is impossible to pass definite judgment upon the adequacy of the average professional net income of physicians in private practice ($5300 in 1929), it is clear that income is much less evenly distributed in medicine than in several comparable professions, and that the *actual incomes are inadequate for a large number of practitioners and more than adequate for some others.* The extent of this mal-distribution is suggested by the wide interval between the middle or median net income of $3800 and the average of $5300. Furthermore, *1/3 of all private practitioners in 1929 had net incomes of less than $2500.* For every physician with a professional net income of more than $10,000, there were 2 who received less than $2500. The contrast is especially great between gen-

eral practitioners and specialists. In 1929, the 70,000 general practitioners, as a group, received less income than the 30,000 complete specialists. The average net income of the former group was under $4000; while that of the latter group was more than $10,000. Physicians' incomes vary widely according to the size of the communities in which they practice. For example, 44% of the private practitioners practice in communities of 100,000 or more of population and their total incomes constitute 54% of the total for all physicians. In communities of 5000 to 100,000 are 26% of the physicians, and they receive 28% of the total income. In the remaining small towns and rural areas are 30% of the physicians, and they receive but 18% of the total income. In other words, the average income of the rural practitioners is less than ½ as large as the average for the metropolitan physicians. Dental incomes show a similar distribution. *Certainly no solution to the problem of medical costs can be reached through a reduction in the average of professional incomes.*

The difference between *gross* and *net* incomes is considerable. The *average gross income* of all physicians, in 1929, was $9000; approximately 40% of which went for professional expenses such as office rent, maintenance and replacement of equipment, salaries and wages of nursing and office personnel, transportation, and other similar items. This large "overhead" of private practice adds to the cost of care to the patient, without financial return to the practitioner; and, furthermore, *must be paid from collections* which in "good times" are on the average *about 20% below the amount charged.*

Physicians in general feel under obligation to give "free work". While it is impossible to estimate the volume of free service, with accuracy, there can be no doubt that its money value is significant. There is some controversy as to who pays for such free service. Some physicians contend that it is their contribution to charity. Another view is that the physician is remunerated by the added experience and the added prestige of hospital and clinic connections, which justify him in charging higher fees to his pay patients. But there are a large number of physicians who have few or no well-to-do patients to whom they can pass along the cost of their free work. To them it is a burden from which they have little opportunity to escape. Even were this not true, the institution of free work would be socially objectionable as a method of distributing the cost of free service, since it would assess this cost on only a section of the well-to-do—those who happen to fall in. The cost of free care at present is either an unjustified burden on the physician or an unjustified burden on those of the well-to-do who seek his services.

The precariousness of the incomes of a large majority of physicians, dentists, and other professional personnel is another serious social problem. The professional net incomes of physicians in communities of less than 5000 population, for example, decreased from 1929 to 1930 by approximately 10% in the Middle Atlantic States, 19% in the New England and Pacific States, and 50% in the Western South-Central States; averaging in all areas 17%. In 1931-32 still further declines were suffered. When practitioners' incomes drop, they do so in part because the people are not purchasing even the customary amount of service, and in part because the physician is being asked to carry individually the community's burden of charitable medical service. The committee believes that neither of these conditions should be tolerated.

One of the worst results of the present method of remunerating physicians is that practitioners may have, or may be thought to have, an economic incentive to create unnecessary medical service or to prolong illness. *It is one of the glories of medicine that so few physicians and dentists, placed in this anomalous position, yield to the temptation.* But it is well-known that some do yield and that, as a consequence, some medical cases are prolonged needlessly, some unnecessary operations are performed, and some necessary operations are performed by surgeons who are selected because of the size of the rebate which they will secretly give to the referring family practitioner.

Another distressing problem is the extensive and increasing unemployment and underemployment among private-duty nurses. Nursing education has been provided at little direct cost to either nurses or the public. Because of the immediate economic gain to hospitals which operate training schools, and the expectation of women that they increase their earning power, women have been trained in ever-increasing numbers regardless of the demand for their services. Furthermore, the quality of nursing education varies widely. As a result of these 2 factors, the profession is greatly overcrowded, some nurses are poorly trained, and employment for the competent as well as the unfit is neither stable nor adequate. Conditions were bad even before the present economic depression. For many competent nurses, the situation is now desperate.

Many hospitals are finding it increasingly difficult to balance their budgets without seriously impairing their efficiency. Except on the Atlantic seaboard, hospitals are customarily expected to be nearly or entirely self-supporting. On the other hand, the community rightly insists that hospitals should keep up-to-date in equipment and facilities, and at the same time should not raise charges to a point which works hardship. The non-governmental hospitals face a crisis. In 1927, an average of only 65% of their beds were occupied and by 1931 it had dropped to 62%. Requests for free service have increased. Income from private philanthropy and community funds has been seriously reduced. Hospitals are not able to pass along any appreciable part of free work costs to well-to-do patients. Expenses cannot be reduced enough without impairment of service. So, there is serious question whether the voluntary hospital system in America can survive. Governmental hospitals have increased in number, in quality of service, and in the proportion of beds occupied. They, however, customarily refuse to serve the very people who, through taxes, contribute most to their support.

Capital Investment in Medical Practice

The physician now needs for private practice a larger professional equipment than formerly and must spend more money and time on his medical education. These requirements make it difficult for the young physician to get under way effectively. Furthermore, the development of hospital work, from a service which 50 years ago was limited in its medical scope and utilized almost entirely by the poor, into a general community enterprise providing service for nearly all major illnesses, has necessitated an enormous capital investment. Over $3,500,000,000 has been invested in land, buildings, equipment, and endowment of hospitals and clinics in the United States. Of this investment, more than 90% has been provided, on a non-profit basis, from government funds or from philanthropic individuals and organizations, without expectation of financial return. The total capital invested in equipment for medical and dental service is estimated at about $5,850,000,000; of which $900,000,000 is the investment by physicians and dentists in their professional equipment and in hospitals owned by physicians; $3,500,000,000 is the investment made by the public without expectation of return; and the balance represents investments in commercial buildings and equipment rented to physicians or dentists for office or laboratory purposes.

An increasing proportion of medical service, therefore, is rendered by practitioners who use a capital investment provided by the public for the benefit of the public. The typical American hospital or clinic is essentially a partnership, or working understanding, between a group of physicians who provide the professional service, and are organized as a Staff for the direction and control of the professional work; and a group of lay persons representing a voluntary organization or a government department, having the legal ownership of the capital and carrying the financial responsibility. This expanding partnership between the professions and the public is one of the most significant aspects of medical practice, but if this relationship is to progress on a sound basis, it will be necessary to develop adequate cost-finding, accounting, reporting, and other technic borrowed from industry.

Provision of Drugs and Medicines

The American people spend annually about $715,000,000 for drugs and medicines. These sales greatly exceed the annual expenditures for dentistry, private duty nursing, or public health, but they have not aroused the same complaints as have the costs of physicians' services and of hospitalization; for many reasons.

The development of the drug store into a department store for many commodities has made the services of pharmacists readily available to the people without unduly high costs for prescribed medicines. But it has surely not retarded the growth of sales of secret-formula medicines, purchased by the patient for a self-diagnosed disease or condition. The annual sales of such "patent medicines" amount to $360,000,000, most of which is money wasted; yet this is 10% of the total spent for all medical services and commodities.

Complexity of Medical Practice

Medical facilities and medical practice, except in some small communities, are growing increasingly complex, and, therefore, confusing to the patient. A considerable proportion of physicians, amounting in some communities to 30%, limit their practice to a specialty, and almost as many more tend toward specialization. Some 25 different specialties of medicine are recognized. The great increase in the number of persons living in large cities and the increased mobility of the population through modern methods of transportation are among the social factors which have decreased the frequency of continuous personal contact between individual families and physicians. Many individual families, particularly in urban areas, find it difficult to discover a satisfactory family physician, and often unwisely choose specialists without the guidance of a general practitioner. There is a wide-spread public demand for usable information. The increased proportion of illnesses cared for in hospitals forces many patients to choose between home and hospital, a choice which they are not always in a position to make wisely. Many persons are confused by these and other complexities of medical practice.

Organization in Medical Service

In one sense of the word, the medical profession is highly organized, with county, state, and national societies, and these exercise an immense and wholesome influence upon standards of training and practice. Many local and national organizations of specialists stimulate both scientific and practical advances. About 2/3 of the 142,000 physicians of the United States are members of their county medical societies, and thus of the state associations and the American Medical Association. These groups are of the first importance for expressing professional standards and opinion, and they play major parts in representing the profession in its relations with educational, industrial, philanthropic, public health, and governmental bodies. Also, another type of medical organization has developed in the United States, where 2/3 of all physicians of the country are now associated with hospitals or clinics. National professional bodies have furnished significant leadership in working out hospital staff organization and procedures which contribute to the efficient care of the patient and to effective relationships among staff physicians.

On the other hand, in many ways, the growing complexity of medical service has outrun the development of its organization. The fact that medical care may now be obtained through an increasing variety of practitioners and agencies, tends to create a lack of continuity in the medical care of the individual patient. During the course of a single year, he may receive from several different specialists services which are not coördinated by a family physician. If he goes to a hospital, he may pass under the care of a physician who was not previously acquainted with his case; and on his discharge from the hospital, the information concering his hospital diagnosis and treatment may not be available for the physician or clinic which becomes responsible for his subsequent care.

The provision of medical care is also unorganized from the point of view of the community as a whole. The educational facilities of a community, on the contrary, are planned and distributed on the basis of the number

of children of various ages. The community's expenditures for education are budgeted, and the relative merits of expenditures for buildings, for equipment, and for teaching staff are discussed and agreed upon. A definite attempt is made to eliminate waste and to maintain standards. Increasingly, building programs for public schools are planned for 5, 10, or 15 years in the future, and this is true not only in metropolitan areas but also in smaller cities and in rural areas. The various persons and agencies concerned—school boards, superintendents, teachers, special consultants—are organized to promote effectively their common efforts in a common task.

There are differences between education and medical service which should be taken into account. The analogy is useful, however, to show that, although medical service is as essential to the national welfare as public education, the task of providing it to all the people has not yet been tackled in an organized and coördinated way.

Cost of Complete Medical Care

If services were organized economically and efficiently, and sold to representative groups of the population among whom there is not an abnormally high rate of sickness, all needed medical care of the kind which people customarily purchase individually could be provided, in urban areas at least, at a cost, excluding capital charges, of $20 to $40 *per capita per annum*. Included in this care would be the services of physicians, dentists, and other personnel, and the provision of hospitalization, laboratory service, radiographs, drugs, eye-glasses, appliances and other items. This estimated cost is based not only upon a theoretic computation of the amount of service necessary to meet the people's real needs and the cost of providing it, but also upon the experience of various organizations that are now providing complete, or nearly complete, service for weekly or monthly fees or without direct charge to the beneficiary. The following figures show the range of these annual *per capita* costs, excluding hospital capital charges which are usually not met from patient's fees:

Cost of adequate medical care—based on Lee-Jones estimate	$36.00
Family population of Ft. Benning, Georgia. (Incomplete dentistry; exclusive of eye-glasses)	30.00
Endicott-Johnson employees and their dependents	21.02
Roanoke Rapids employees and their dependents (No dentistry; exclusive of drugs and eye-glasses)	17.46
University of California students (Selected population—9 months only)	14.59
Employees of Homestake Mining Company and their dependents (No dentistry or home nursing)	12.48
Families subscribing to Ross-Loos medical service (No dentistry or nursing: exclusive of eye-glasses)	10.84

On the whole, the services provided at these places are of good quality, although not in every instance the best that could be asked or that could be obtained if larger funds were available. At Fort Benning, the care is of exceptionally high quality and wide range, including unlimited hospitalization and the services of all ordinary specialists; only dentistry appears inadequate. Both in scope and volume of service and in cost, this organization supplies medical care which approximates the requirements of "good medical care".

Each of these organizations provides its patients with a substantially larger volume of services than most persons receive for approximately the same expenditures. This is made possible: (1) by organization of the services so that the time of practitioners is conserved and the medical facilities are used efficiently; and (2) by the provision of service on such financial terms that patients are encouraged to obtain care in the early stages of illness, thus probably reducing somewhat the number of difficult cases.

Low-income families usually cannot, however, pay an annual cost of $20 to $40 *per capita*. A family of 5 with an income of $1500, for example, would have to spend $100 to $200, or 7 to 13% of its income, to pay for such service. Anyone familiar with the budgets of families in this income group knows that such an expenditure for medical service would entail severe hardship. As was shown above, an annual cost of $30 *per capita* is well within the *collective* resources of the country.

Even a cost of $40 *per capita* would have constituted in 1929 less than 6% of the *total* money income of the country. Unless the national income increases so rapidly that many of the families at the lower end of the economic scale are enabled, on a periodic payment basis, to meet such costs, some method of tapping the combined resources of the population must be found.

Needs Which Should Be Met

To focus attention on those problems which called the Committee into being, we list those deficiencies in the provision of medical service which seem to be within the power of the American people—professional and lay, separately or together—to overcome at the present stage of medical knowledge.

(1) The people need a larger volume of scientific medical service than they now utilize.

(2) Modern public health services need to be extended to a far greater percentage of the people, particularly in rural areas, towns, and small cities.

(3) There is need for a better geographic distribution of practitioners and agencies which would more closely approximate the medical requirements of the people.

(4) In rural and semi-rural areas, the current expenditures for medical care are insufficient to insure even approximately adequate service, to support necessary facilities, or to provide satisfactory remuneration to practitioners.

(5) There should be an opportunity for many practitioners to earn larger net incomes than they now receive. This is particularly true of well-trained recent graduates, who frequently must practice for 5 to 10 years before they attain an adequate income. The incomes of general practitioners and of specialists should be more nearly equal than at present, and the opportunity and incentive for "fee-splitting" should be removed.

(6) There needs to be better control over the quality of medical service, and opportunities should be provided for improving quality as rapidly in the future as it was improved in the past. Practice by unqualified "cult" practitioners should be eliminated, and control should be exercised over the practice of secondary practitioners, such as midwives, chiropodists, and optometrists. The practice of specialties should be restricted to those with special training and ability; more opportunity for post-graduate study should be available for physicians, particularly rural practitioners; and there should be constant chances for physicians to exchange experiences and assist one another. The work of certain physicians and dentists, who even though they are regularly licensed are nevertheless not competent for many functions, should be closely controlled and improved through supervision and further education.

(7) There should be more effective control over the number and type of practitioners trained, and their training should be adjusted so that it will prepare them to serve the true needs of the people.

(8) There is a need for reduction of waste in many directions. Substantial sums are wasted on unnecessary medication; on the services of poorly qualified or utterly unqualified "cultists"; in the idle time of physicians, dentists, nurses, and other practitioners; in the high "overhead" of private medical and dental practice; in unused hospital accommodations; and in the time of patients who go from place to place seeking medical service.

(9) The prevailing methods of purchasing medical care have unsatisfactory consequences. They lead to unwise and undirected expenditures; to unequal and unpredictable financial burdens for the individual and the family; to neglect of health and of illness; to inadequate expenditures for medical care; and often to inequable remuneration of practitioners. There needs to be some plan whereby the unequal, and sometimes crushing, burden of medical expenses can be distributed.

In view of the wide-spread waste and planlessness of effort and expenditure, it is amazing that so much is done. Physical facilities are duplicated between the hospitals and the offices of practitioners and are insufficiently utilized in both. Hospital beds are empty and much of the physician's, dentist's, and nurse's time is idle, while many persons suffer and many die for lack of medical attendance. Mis-

directed expenditures, competition and excessive specialization among practitioners, and the absence of community planning, and of integration of services and facilities, contribute to extensive waste.

Responsibility for Present Situation

The present complicated and unsatisfactory methods of providing medical services; the whole group of arrangements and devices through which medical knowledge is translated into service; result from generations of growth. No one person and no one group of persons planned present conditions or can be held responsible for them.

This fact does not mean, however, that medicine is irrevocably tied to present devices. *Social conditions are constantly changing and medicine will change with them.*

This survey leads the Committee to the following general conclusion. The 1,000,000 persons who furnish medical care, and the 123,000,000 who may receive it, should make concerted and carefully planned efforts to meet needs and to devise remedies for present deficiencies and wastes.

The present situation is a result of growth in the science of medicine, in the arts and organization of practice, and in the changing structure and attitudes of our urbanized and mobile civilization. Medical care is essential. While it requires substantial expenditures, its absence or inadequacy involves still greater costs. The organized professions of medicine, dentistry, pharmacy, and nursing; the organizations of employees and of employers; the civic, social welfare, and governmental agencies; all have a stake in this problem and ample reasons for bending energies toward its solution. None of the major problems of medical care can be solved by any one group alone. Those who furnish the services, on the one side; and those who receive and pay for them, on the other; must coöperate if either is to meet the needs which they perceive or to attain the benefits which they desire.

CHAPTER II

Essentials of a Satisfactory Medical Program

Many of the problems discussed in the previous chapter have long engaged the attention of practitioners and laymen. A multitude of plans and experiments have been brought forward to solve some or all of them. These plans and experiments present an almost infinite variation in completeness, in quality, in the treatment accorded to practitioners, and in cost. In evaluating any experiment or in formulating a plan for the provision of medical service, it will be useful to have a clear statement of the essentials or criteria by which soundness and effectiveness may be judged. There appear to be 6 basic essentials, as follows:

(1) The plan must safeguard the quality of medical service and preserve the essential personal relationship between patient and physician.

(2) It must provide for the future development of preventive and curative services in such kinds and amounts as will meet the needs of substantially all the people and not merely their present effective demands.

(3) It must provide services on financial terms which the people can and will meet, without undue hardship, either through individual or collective resources.

(4) There should be a full application of existing knowledge to the prevention of disease, so that all medical practice will be permeated with the concept of prevention. The program must include, therefore, not only medical care of the individual and the family, but also a well-organized and adequately-supported public health program.

(5) The basic plan should include provisions for assisting and guiding patients in the selection of competent practitioners and suitable facilities for medical care.

(6) Adequate and assured payment must be provided to the individuals and agencies furnishing the care.

When, hereafter, in this report, the Committee speaks of a "satisfactory medical service", it means a service which meets all these

essentials, which will now be briefly considered; an ideal embodiment of them will be suggested in Chapter III and specific recommendations presented in Chapter V.

Safeguarding Quality of Medical Service and Personal Relations

No plan is economically sound which does not safeguard quality, since efficient service is, in the long run, the most economic. Any plan should be judged, therefore, primarily by the effect it will have upon the quality of medical service. If it necessitates hurried or impersonal work; if it does not permit physicians and other practitioners to keep up-to-date, through post-graduate study and contact with their fellows; if it develops an antagonistic relation between physicians and patients, so that confidence is lacking; if it sets up devices that put the practitioner's economic and his professional interests in conflict; or if it isolates certain practitioners from necessary association with others; these defects must be corrected or the plan condemned.

The preservation of a personal relation between patient and physician is an essential element in safeguarding the quality of medical practice. This relation, as the Committee defines it, includes "not only the privileged confidential communications of patient to physician, which are recognized as inviolate by law, but also the relation involved in the communication of his medical history to any physician chosen by the patient and *the continuing mutual responsibility between patient and physician*. This in no way inhibits the patient from giving his confidence to different physicians or to the medical integrator of a group of physicians. The business relation between physician and patient is not considered a necessary part of the personal relation as defined above nor does the definition carry a commitment for or against any scheme of organization of medicine."

Medical care, by its very nature, is and must remain a distinctly personal service. Although the personal element is relatively less significant in some specialties or special services, it should always be considered. Man is not a standardized machine and each individual reacts to the conditions of life in a manner, in some respects, unique. To make an accurate diagnosis, and to adapt treatment to these individual variations, the physician himself must see his patient and see him, in many cases, over an extended period of time. The physician needs continued contacts and study to enable him to treat the patient as a human being, in a family and a social environment, and not merely as a complex of symptoms. The choice of the patient should determine the selection of the physician. Most significant of all, the physician must have the opportunity to establish himself as the trusted adviser and confidant of the patient on all matters affecting health. Confidence is frequently more important than drugs.

There is nothing in any way mysterious in the relation between a physician and his patient. On the therapeutic side it is capable of completely objective analysis. As to those phases which are not strictly medical, it is of a piece with all satisfactory human relations involving as they do mutual patience, sympathy, understanding, and confidence.

Under present conditions, the old-time relation with a family physician is often disturbed, partly because the family physician may not have maintained an adequate standard of knowledge and skill, and partly because confusing relations have arisen with independent specialists, clinics, and hospitals. The family physician should be restored to his place of responsibility and trust, and his potentialities extended by substituting coördinated for uncoördinated relations with specialists and other agencies which permit him to do his work effectively.

Provision for Meeting the People's Real Needs

A concerted attempt should now be made in the United States, with consideration of economic and geographic variations, to supply *all* the people's needs for *good* medical service. The amount of care which people need is far greater than that which they are aware of needing, and greater than that for which they are able to pay under present conditions. In view of the lethargy and active opposition usually encountered in effecting changes, how-

ever desirable, it may not be practical to supply all the people's needs at once, but any plan to be satisfactory must provide for the continuous development of its component services until eventually they cover all the needs of all the people.

Provision of Service on Acceptable Terms

If adequate services are available but can be obtained only on financial terms which a large number of persons cannot or will not meet, the problem is not solved. Most communities, in officially assuming at least a theoretic responsibility for the care of indigents, have already taken the position that no human being should be allowed to suffer, on account of poverty, from remediable illness or distress. Our present system, however, on the one hand, lays an unjustifiable burden of unpaid service upon the physician and the hospital; and, on the other hand, frequently gives the individual of the middle economic level only a choice between becoming a recipient of charity or foregoing needed medical care. A satisfactory program should make it possible for a large proportion of the total population to pay in full whatever may be charged for needed medical service, on terms which are reasonable and which fully preserve self-respect. The cost of care for those who cannot pay should be distributed, according to ability to pay, over the rest of the community.

Emphasis on Prevention

Preventive service to patients, and instruction and guidance in the basic principles of personal hygiene, should form an increasing part of the individual physician's work, whether in his office, in the patient's home, or in the hospital; and organization, both of service and of payment for service, should be such as to facilitate the widest application of preventive medicine.

Public health services should be adequately supported. All parts of the country should be provided with the basic public health activities, namely: (1) the collection of vital statistics; (2) control of the water, milk, and food supplies; (3) control of sanitation; (4) the control of communicable diseases, especially tuberculosis and venereal disease; (5) provision of laboratory service; (6) popular health instruction; (7) promotion of maternal, infant, and child hygiene, including school health service; and (8) the organization of other special services when needed for the prevention and treatment of malaria, hookworm or other diseases which constitute special health problems. Popular health education should be carried on by schools as well as by health departments and medical practitioners. These developments require better financial support for public health work and a trained personnel, with tenure dependent only upon technical and administrative competence.

Selection of Competent Practitioners

The physician is the first "contact man" between medical science and the people; occupying the front-line trenches in man's warfare with disease. It is vital, therefore, that he be competent and qualified for his work. Since medical service is a "commodity" the value of which the patient cannot correctly judge, it is important that he be assisted in the selection of practitioners and facilities.

Adequate Payment to Practitioners and Agencies

A major essential of a satisfactory medical service is the provision of adequate compensation to physicians, dentists, nurses, and other scientific practitioners, and adequate support to hospitals and other agencies. The training required for those who render service is long, arduous, and costly, and their responsibilities are exacting. They should be paid accordingly.

All practitioners should receive sufficient compensation, and the conditions under which they work should be such as to make certain that high-grade men and women will continue to be attracted to these professions and will find it possible whole-heartedly to devote their time and attention to their professional work. Many hospitals and health agencies likewise need a more nearly adequate and stable basis of support. The necessary money should come either from the individual patient directly or from some central fund to which he has contributed all or part of the amount needed for his care.

General Lines of Approach

In order to obtain such a satisfactory medical service, three major lines of approach are needed:

(1) The development of types of organized or group practice that will more effectively and economically meet the community's medical needs.

(2) The distribution, over a period of time and over a group of families or individuals, of the costs of service.

(3) Provision for the planning and coordination, on a local and regional basis, of all health and medical services.

Provision of Service Through Organized Groups

Most physicians and dentists are independent practitioners, dealing directly with their patients, and individual responsibility for the quality of service rendered must be retained to assure good professional care.

During the past 2 or 3 decades, however, various developments in medicine have made it increasingly important that service be coordinated and organized. First and most important, is the rapid advance in medical art and knowledge, and the growing necessity for specialization and a division of labor. No man can now master all medical knowledge and develop all the skilled technics. Not only have specialties developed, therefore, in medicine itself, but numerous related or subsidiary professions and technical occupations have arisen. Many patients now go directly to independent specialists, without first consulting a general practitioner. This practice increases the complexity and the cost of medical service and tends to relegate the family physician to an unimportant place.

A second development is the increased capital investment required for the study, diagnosis, and treatment of disease; so that those who work alone are unable to afford the costly and varied equipment necessary; nor do they have the time to become proficient in its use. The well-qualified general practitioner can, indeed, care for a large proportion of illnesses, but to realize his ideal possibilities, he needs, in many cases, association with specialists and access to the facilities of a good hospital.

A solution for these difficulties lies in the organization of general practitioners and specialists into groups for achieving the benefits of closer professional relations and economic use of equipment and assistant personnel. The Committee's studies have described examples of group practice which demonstrate that certain advantages can be realized. It is obviously more economic to provide hospital facilities and scientific equipment to a group of physicians practicing coöperatively than to the same number working independently. *Competent management,* of both the business and the professional aspects of practice, and *adequate organization and direction of subsidiary personnel* can be assured more readily to a group. Group practice can be made to stimulate professional improvement: through the provision of adequate equipment; sufficient time for study and post-graduate work; and, above all, through the mutual criticisms of colleagues. Younger men will be stimulated by the knowledge that advancement depends upon the sober judgment of professional seniors rather than the relatively uninformed choice of the laity. Through daily coöperative work, group practice tends to break down the separatist (solitary) habits of thought and action which beset the specialist; and also to create a form of organization which makes a place, but no more than its due place, for each specialty. Group practice may materially assist in *bringing specialists* into proper *relation with* one another and with the general practitioners.

Some dangers of group practice, are: (1) The medical group may become so large that not only patients but some of the practitioners may become mere cogs in a machine and the *personal relation be lost;* (2) some practitioners *may lose* individual initiative if their existence is assured by the group; and (3) the desires of older men to keep their grip on power, and the ambitions of younger men to attain it, can be more effectively destructive within an organization than they can between independent competitors.

Standards for Group Practice.—To avoid these possible dangers, and to realize fully the

advantages of group practice, *standards* (of conduct for the group members) should be *formulated* by a joint commission appointed *by appropriate professional associations.* The most important standards are:

(1) General Medical Care.—The professional group, giving general medical as well as specialist service, should include physicians with the training and point of view of the general practitioner. (The term "family or general practitioner" is used to mean the physician in a group who handles, in the first instance at least, all or the major part of the calls from his group of patients and who *maintains the personal relation with patients.*)

(2) Coördinated Diagnosis and Treatment.—Members of the group should coördinate their service and pool their knowledge, so as to give each patient the best possible diagnosis and treatment.

(3) Individual Responsibility.—The group should hold some particular physician responsible for the care rendered to each patient. This physician should be chosen by the patient or chosen for him at his request. It should be this physician's duty to interpret the findings made by any other physicians consulted. Continuity of relationship, year after year, between the patient and the physician should be strongly encouraged.

(4) Promoting High Standards.—Systematic procedures should be carried on by the group for the professional stimulation of members and the maintenance of high standards of work.

(5) Association with a Hospital.—Whenever possible, the group should be associated with a hospital, often constituting its professional staff and, preferably, having offices in or adjacent to the hospital building. In any event, the same group of doctors should be responsible for the care of patients in office, home, and hospital.

(6) Professional and Lay Participation.—Where groups associate with a voluntary or governmental hospital, the Board of Trustees of the hospital will usually continue to carry the financial responsibility and exercise general administrative supervision; the professional group should have definite control over professional policies and procedures and full opportunity to discuss with the lay group those problems in which professional and administrative questions are intermingled.

(7) Non-Profit Character.—The danger which physicians and dentists principally fear —*that lay groups organized for profit will control medical practice*—is a real one. Such groups, they believe, will place the practitioners in subservient positions, will deny them proper equipment and professional opportunities, or in other ways will prevent them from rendering service of a high quality or from receiving adequate compensation. Such groups add to the cost of service without contributing any essential element which cannot be provided equally well by non-profit professional or community groups. It is far better for the organizing activity, the capital investment, and the assumption of financial risk to come from non-profit making community, religious or governmental hospitals or similar agencies. The Committee believes that *lay groups organized for profit have no legitimate place in the provision of this vital public service.*

Insurance.—The Committee defines insurance as a procedure by which a group of persons pay uniform sums of money to meet the costs of medical care. The principal of insurance is universally familiar as applied to fire, death, accident, and many other risks. In connection with illness there are 2 financial risks: (1) the costs of medical care, and (2) the loss of income during illness. There are 2 major methods of distributing costs: (1) insurance; (2) taxation. Extensive experience in this country and abroad has shown that the wage-earning population evinces more interest in financial protection against loss of income due to illness than in the provision of medical care. If there are no savings, complete stoppage of income because of the illness of a wage-earner immediately threatens the whole family with destitution. *All foreign systems of health insurance which have developed on a large scale have met this widespread demand by including provision, not only for medical care, but also for cash benefits to meet a part of the wage-loss.*

Studies available to the Committee have

made clear that serious *difficulties arise when the administration of cash benefits is united with the provision of medical care.* The amount of cash paid in any case necessarily depends upon a medical certification of the existence and degree of disability. It is to the interest of the insured *group* as a whole to keep cash benefits down, whereas the insured *individual* naturally wishes a generous benefit in his particular case. Physicians who endeavor to serve both interests simultaneously, find it difficult to do so, and at the same time fulfill their primary professional responsibility for adequate diagnosis and treatment. In several foreign systems of health insurance, this has been a major source of controversy, ineffectiveness, and sometimes of heightened costs. The demand for income protection during illness, however, must be met for large numbers of wage earners, and the problem of medical certification is inherent and must be dealt with so as to minimize the difficulties. Recommendations as to methods of meeting the need for income protection lie outside the scope of the Committee's work, but it here emphasizes its sense of the importance of this need. The Committee insists that there shall be a *clear-cut separation between insurance to meet the costs of medical care and insurance to cover a portion of the wage loss due to illness.*

Taxation.—Tax funds now meet about 14% of the nation's annual medical bill. Nearly all hospital care of mentally diseased, most hospital treatment of tuberculosis and other communicable diseases, and all work of health departments are maintained by taxation. The same is true of the care of military and naval personnel, of inmates of prisons and other wards of the state, and is theoretically true of general medical care of so-called *indigent* persons. These are accepted forms of *state medicine,* a term which the Committee uses to cover the provision of medical care by the government. It should be observed, however, that the mere use of tax funds as a means of paying certain costs of medical service does not of itself constitute *state medicine,* since some tax funds pay for medical service which is administered in voluntary hospitals or by individual physicians in private practice.

The major present tax outlay for medical care is for hospital service. The capital investment in governmental hospitals was estimated in 1928 at over $1,400,000,000; the operating costs of 1930, as $303,000,000, or about 46% of the total operating costs of all hospitals. Of the $303,000,000, about $185,000,000 was for hospital care of patients having mental diseases or tuberculosis, and the remaining $118,000,000 for general hospital service. More than half of the general hospital care is provided by cities and counties through local hospitals. A few states provide general hospital service directly and some furnish subsidies to local institutions. Such general hospital service as is furnished by the Federal Government is for special groups only —veterans, soldiers, sailors, and inmates of certain institutions. There is substantial agreement that it is proper to use tax funds to provide organized preventive work and care of certain diseases—like tuberculosis—which are a menace to the community, and those like mental disease, which can be adequately cared for in no other way.

Taxation is peculiarly necessary where there are wide divergences in the financial resources of different localities, and where the tax is levied by the state or some unit larger than the locality. Medical needs arise, roughly speaking, in proportion to the size of the population, but the ability to pay is in proportion to resources. The Committee believes that the primary responsibility is local but that where local funds are insufficient supplementary aid should be given from, preferably, the next larger governmental unit.

Planning and Coördination of Service.—There should be an agency in each community through which the lay and the professional groups concerned in providing and financing medical services could consult, plan, and act in behalf of the best provision of medical resources which the community can afford. To a limited extent and as yet in only a few communities, local health and hospital councils have performed this function. Physicians and other professional groups especially concerned should be adequately represented in these coordinating bodies. Those concerned with providing funds should also be represented and

should give careful attention to the needs of planning and coördination.

The state is also the natural body to insist that medical organizations meet reasonable minimum standards of quality in their medical services, but the *standards themselves should be formulated by national or state professional bodies.* But such bodies are usually not in a position to insist on observance of their standards, nor is the control of community agencies necessarily among their proper functions. The *public must be protected from inferior medical service, and the professional personnel from exploitation.* A state coördinating board would be a logical body to enforce these minimum standards.

CHAPTER III

An Ultimate Objective in the Organization of Medicine

There is a growing conviction that social evolution may be guided wisely and that it is statesman-like to formulate the objectives of such evolution. What is true of society is true of medical service, for so long as society is on the march, medical service will inevitably be on the march, too, and practitioners should have a clear vision of the goal ahead. The Committee presents its conception of an adequate type of medical organization and an effective method of paying for medical service. This should be the major objective, during the next 25 years, of communities which seek to solve the problem of providing satisfactory medical service.

It has been shown that many persons are obtaining inadequate medical care at rates which for them are excessive; and that many persons who give this care are receiving inadequate compensation. A remedy lies in the organization of producers and consumers. Organization in the field of medical care may come through private initiative or through the initiative of the government. *That such organization will come seems inevitable. Whether it comes through governmental or non-governmental agencies depends more upon the initiative of the professions and organizations involved than on any other one influence.* There are undoubtedly parts of the country where governmental initiative is the only solution. The kind of organization outlined in this chapter constitutes an objective for either governmental or non-governmental effort; it embodies the best features of many existing plans, and avoids, so far as possible, their disadvantages and limitations.

The Organization of Services

The basic advance in achieving the objective here outlined is the provision of medical service by cohesively organized groups of the various scientific practitioners and agencies in the medical field working under a common direction and with a common purpose. Different types of organization are presented for cities, towns, and rural areas in order to take account of their differences in economic and social conditions.

The keystone of the concept of a satisfactory medical service for the nation is the development of one or more non-profit-making "community medical centers" in every city of approximately 15,000 population or more.

This center would include a well-equipped general hospital, an out-patient department, and a pharmacy. It would provide offices for physicians, dentists, technicians, and subsidiary personnel, and headquarters for nurses. All facilities necessary for the practice of modern scientific medicine would be available.

Professional aspects of the service would be under the control of the professional personnel of the center.

All, or nearly all, practicing physicians and dentists of the areas served would eventually be on the staff of the single center in a small city, or the several centers in a metropolis. A few physicians and dentists and perhaps a considerable number of pharmacists would undoubtedly prefer to continue indefinitely in individual practice. If there were an oversupply of practitioners, the State Coördinating Board would assist the surplus personnel in finding locations where their services were needed and where they could earn reasonable returns. The personnel of the center would be remunerated on a salary basis, on a capitation or fee basis, or by a proportional division of receipts; some method combining sev-

eral of these bases might prove satisfactory. Whatever the basis of remuneration, the total funds available for compensation of the professional personnel would be divided, so far as possible, according to each practitioner's competence and responsibilities, as determined by the Board of Trustees, the Director, and the Physician-in-Chief or the Executive Committee of the Staff, and be sufficient to attract to the staff, for the major positions, the ablest men in the community. Definite arrangements would be made for vacations, for leaves-of-absence for post-graduate work, and, as the finances permitted, for retirement allowances. Within the medical center, the rôle of the family practitioner would be prominent and respected, and some of the family practitioners might be among the best paid men on the staff.

The 45% of the American people who live in "metropolitan areas" of 100,000 or more population, and the additional 7% who live in cities of 15,000 to 100,000 population would be served by such centers or their city branches. People in the surrounding areas, within perhaps 10 to 20 miles of the central city, would also be served by the metropolitan medical centers and branches. Thus, at least 50 to 60% of the population would be in direct touch with a center which provided the very best that modern medicine could offer. In towns of 2500 to 15,000 which are not part of metropolitan areas, there are about 10% of the population. Since most of these places are too small to support separate full-sized community medical centers, several places would combine, where feasible, to support a complete center; and where this is not possible, a smaller unit could be established in connection with an existing hospital or a small hospital to be built. For villages and distinctly rural areas, which contain about 38% of the population, a series of "medical stations" would be strategically located; each station under supervision of a complete medical center or an affiliated branch. Through the linkage of medical stations to affiliated branches, and of affiliated branches to community medical centers, the entire population would be provided with complete, adequate, supervised medical service; yet a large degree of autonomy and responsibility would be retained locally.

Existing Bases for Organization

The development of medical centers, branches, and stations can and should come as a natural evolution of existing organizations in the medical field.

Although community medical centers, affiliated branches and medical stations, eventually would provide a large proportion of the medical and health services needed by a community, their development will take years of effort. In the meantime, many existing practitioners and agencies will continue to carry on their important services. Furthermore, these proposed medical centers will never supersede or embrace all the existing medical institutions and agencies. Individual private practice, particularly among the well-to-do, will continue indefinitely; public health activities are a permanent governmental responsibility; industrial organizations will continue sanitary and preventive services to employees; and governmental provision of hospitalization for tuberculous and mental patients will probably increase.

Cost of the service provided by a medical center, branch, or station would vary in different communities because of differences in: (1) the adequacy of existing facilities and the necessary expenditures for new land, buildings, or equipment; (2) the compensation to practitioners, which would depend in part on the costs and standards of living; and (3) the degree to which various refinements of service would be expected and required by patients. Assuming, however, that practitioners are compensated on the average as well as they now are or even somewhat better, and that hospital costs approximate the average in good institutions; the total cost, exclusive of capital charges, of a complete service by community medical centers would fall somewhere between $20 and $40 per capita, per annum.

This cost could be met: (1) by insurance paid for in full by the individuals or families

served, with or without assistance from their employers; (2) by the use of tax funds, local, state, or both; or (3) by a combination of insurance and taxation.

It should be pointed out that the health insurance here described differs in 3 important respects from the types offered in most European countries. In the first place, *this system is predicated upon service being provided by organized medical groups rather than by individual practitioners.* Many of the difficulties experienced both by patients and by practitioners under European systems will be avoided, the Committee believes, if service is obtained from well organized groups, since such groups will be far better able to maintain their legitimate interests, and their proper and socially desirable professional standards, than individual practitioners. Furthermore, economies can be realized in group practice which are impossible in purely individual work. In the second place, this insurance is completely divorced from any system of income protection through cash benefits. Many of the worst abuses of health insurance abroad have arisen because of the desire of insured persons for financial rather than medical assistance. *Unquestionably there is a need for income protection, but any system of cash benefits should be separate from the provision of medical service.* The Committee's *recommendation of group practice and group payment* is subject to the condition regarding non-profit-making, previously discussed, and to the following additional conditions: (1) That the group be so organized that adequate standards of service can and will be maintained, and (2) that the practitioners be fairly compensated with due regard to their education, responsibilities, and community status.

The Committee's Summary. The system outlined constitutes a goal for community effort in the organization of medical service. Some features of it are impractical at the moment because of the present state of mind of the American people and of the professions concerned. Other features are not feasible immediately in the face of existing economic and social conditions. The plan as a whole, however, and all the essential elements in it are within the range of practicability within the next 2-3 decades.

Attainment of this goal will bring many advantages. First and most important, it will bring to all or nearly all the people a much wider participation in the benefits of modern medical knowledge. There would be little or no occasion for people to deny themselves skilled medical attention because of inability to pay, since even in relatively sparsely populated districts there would be a minimum of good care available and the quality of medical service would be under constant and effective control by professional and governmental agencies. The fact that good medical care would be available at costs which the people could pay would tend to wean patients from poorly trained or substandard practitioners and to discourage self-prescribing and the use of patent medicines; both the need and the opportunity for "fee-splitting" would disappear. (These statements, with reference to destruction of *cults* and of *fee-splitting,* seem reasonable; and, certainly constitute "a consummation devoutly to be wished".—Ed.)

The majority of practitioners, dentists as well as physicians, would gain through more assured and stable incomes; opportunities for vacations and post-graduate study; openings for young well-trained practitioners; adequate facilities for conducting modern practice; and close association with professional colleagues. They would also benefit from the fact that the supply of practitioners could be more closely adapted to the need for their services. The most difficult problems of nurses—security of income and opportunity for advancement—would be largely solved.

Society as a whole would receive substantial and hitherto unrealized dividends from its investment in medical research and education. With the facilities of the country more effectively utilized, there would be a marked improvement in the health, happiness, and peace of mind of the American people.

CHAPTER IV

Plans and Experiments Now Under Way

Both—practitioners and laymen—have long been aware of some of the deficiencies in medical practice to which reference has been made. Aside from the traditional methods of medical practice with which all are more or less familiar, a variety of suggested solutions has been tried in various parts of the world. The Committee and coöperating agencies have gathered data on the most significant of these plans and experiments in the United States; 4 sponsored by professional groups and 4 by consumer groups. The largest number, 13, have developed under community groups, some voluntary and some governmental, but with the participation of professional groups; 1 is sponsored jointly by professional and consumer groups and 3 by commercial agencies. In addition, the Committee has been provided with the findings of 2 recent studies of European health insurance organizations.

The 4 Plans Under Professional Sponsorship

(1) *Care of indigents by County Medical Society.* During the past few years at least 10 county medical societies in Iowa, and a few in other states, have contracted with their local governments to provide medical care to the indigent; *i. e.,* persons officially understood to be recipients of charity, in return for annual payments by the local governments. (The "Iowa Plan" was described editorially in our State Society Journal of January 1931, pages 49-50, and we recommended it for trial by some of our County Societies.—Ed.)

The advantages of this experiment are that it places definite responsibility on the County Medical Society to care for the indigent, and on the local authorities to pay the physicians for their services. Control over the quality of service and division of compensation is left in the hands of the organized profession.

(2) *Health insurance provided by County Medical Societies.* A type of health insurance was proposed during the Summer and Autumn of 1932 by a committee of the Medical Society of Milwaukee County, Wisconsin. It suggested the formation of "The Community Medical Service of Milwaukee", under a joint medical and lay executive board, to enroll individuals and groups of persons who would pay regular monthly dues (based on incomes) in return for designated professional services. These services would be provided by any member of the County Medical Society who wished to participate in the plan. Subscribers would be allowed "free choice" among the participating physicians and institutions.

(3) *Joint use of professional personnel and equipment.* In many cities, groups of 3 to 20 physicians or dentists have reduced their overhead costs through joint utilization of office space, waiting rooms, scientific equipment, and technical and clerical personnel. Instead of referring x-ray procedures and laboratory tests to other practitioners, for example, some such groups pool the expenses of maintaining x-ray and other laboratory personnel primarily for their own patients. Some groups jointly employ a lay business-manager. Customarily the participants in such a plan maintain separate financial relations with patients and complete professional independence. Often the groups are composed exclusively of specialists. Thus certain economies are effected and physical proximity facilitates consultation and saves the time of patients. Such arrangements do not, however, aid the patient who needs a general practitioner, nor provide a sure method of directing patients to the right physician. Furthermore, there is no effective professional control over the quality of service, nor any assurance that economies will be shared with patients. Such arrangements may be considered as temporary phases of the transition from individual practice to private group practice.

(4) *Private group clinics.* The idea of group practice in medicine has developed rapidly in the United States, particularly since the World War. The distinguishing features of a private group clinic are: (a) its physicians are engaged in the coöperative practice of medicine and use many facilities in common; (b) all, or most, of the physicians are engaged full-time in clinic work; (c) 2 or more of the major specialties are represented on the clinic's staff, and an attempt is made

to give complete service to all accepted patients; (d) patients, although frequently under the charge of a single physician, are the responsibility of the whole group; (e) financial responsibility rests with an employed business manager; (f) the income is "pooled" and the remuneration of practitioners determined by agreement among the practitioners, rather than according to the services rendered. There are now about 200 such clinics in the United States.

A variation of the private group clinic is the diagnostic clinic, sometimes conducted by physicians as a self-supporting enterprise, and at other times conducted with semi-charitable intent. In the diagnostic clinic a group of specialists join to diagnose obscure conditions. Such clinics usually accept only patients who are referred by physicians, and send the patients back to the referring physician for treatment. Frequently, a flat fee of $50, $75, or $100 is charged for a complete diagnostic examination and report. Such clinics are feasible only in large metropolitan areas where there is a substantial stream of patients; and they have rarely been successful except when associated with the staff organization and therapeutic services of a hospital or general clinic.

There are two-fold advantages to group clinic practice: advantages to the patient and advantages to the practitioner. Briefly, the advantages to the patient are that he may receive a better quality of care from a well-rounded group, than he would from individual physicians practicing independently and without intimate and continuous contact with each other. This is a special advantage to the patient with an obscure illness or one difficult to treat. The clinic as a whole assumes responsibility for the quality of the patient's care, and he finds it convenient to obtain the services of all needed specialists in one place and as part of one arrangement. From the physician's point of view, clinic organization has the advantages that: his time is conserved; the spread between gross and net income is diminished; a large amount of equipment is usually available; consultation with colleagues is facilitated; vacations and opportunities for post-graduate study are more readily provided; net income tends to be higher and stabilized; records are more nearly complete; and research is facilitated through the existence of a larger number of records.

(The Committee report proceeds to explain the 21 other plans indicated above as being sponsored by "community groups"—"professional and consumer groups"—and, "governmental or commercial agencies"—but as they are not of vital importance to this abstract, we will merely list them, and comment upon some in such manner as will, perhaps, make them recognizable to our readers.)

(5) *Medical service under workmen's compensation.* About 44 states have workmen's compensation laws, most of which require the employer to provide money compensation and medical services to such of his employees as are injured while working for him. Service under workmen's compensation legislation, even though inadequate in some instances, has undoubtedly been of great benefit to injured workmen and has been satisfactory to physicians in some states as, for example, in Ohio where there is a state insurance fund and where the fee schedule was approved in advance by the state medical society. In some other states, there has been constant bargaining between the physicians, interested in receiving adequate payment for their services, and the insurance companies, interested in keeping down the costs of service.

(6) *Medical service furnished by employers.* There has been in recent years a substantial growth in both the quality and the amount of medical service provided by industries or by groups of employees.

Some industrial medical service is comprehensive and of good quality. The Endicott-Johnson Corporation, for example, provides its employees with the services of general practitioners and specialists, hospitalization, dentistry, nursing, and laboratory and x-ray service. The service compares favorably with general practice in small cities, and in preventive medicine and obstetrics is better than that ordinarily received by working class families in small cities. In 1928 this service cost the com-

pany $21.81 per individual to whom it was potentially available.

(7) *Medical service provided by employee groups.* There are several hundred employees' mutual benefit associations which provide various kinds of cash and other benefits to their members.

(8) *Medical service provided jointly by employers and employees.* The *advantages* of industrial medical service, whether furnished by the employer, the employee, or both, are in general similar, namely: (a) the form of organization makes possible a method of financing which provides more medical care than most persons in similar economic groups are able to afford under private practice; (b) the economic inhibition against seeking service early is removed; and (c) physicians' incomes are larger than in private practice among people of the same general economic group in communities of similar size.

The *disadvantages* of this type of practice are: (a) since the management and direction of the service are almost entirely in the hands of laymen, it is possible for proper professional standards to be disregarded; (b) the practitioners lose some of their personal and professional independence; (c) such a system may unfairly exploit the services of physicians.

(9) *Middle-rate hospital services.* A number of voluntary hospitals in this country are now developing special plans for the so-called "patient of moderate means". The most significant feature of these, as illustrated, for example, by the Baker Memorial unit of the Massachusetts General Hospital, is an agreement between the medical staff and the hospital on a fixed maximum schedule of charges for professional as well as for hospital services, and the adjustment and collection of these charges by the hospital administration, acting on its own behalf, and as the agent of its medical staff. An effort to reduce the cost of special nursing is usually an additional feature. (Note the Orange Memorial Hospital Plan, Jour. Med. Soc. N. J., Dec. 1932, p. 975.)

(10) *Pay clinics.* Out-patient departments of hospitals and clinics independent of hospitals were originally only for the very poor. Increasingly they have come to serve persons who are not indigent, but who cannot meet the usual expense of private medical care. Some pay clinics, like the Cornell Clinic in New York City, provide general services; others are limited to special fields.

Pay clinics furnish good care to persons of small means at a much lower cost, due to the economies of organization and the limitations on the returns to practitioners, than the cost of equivalent service in private practice; but they compete with some local medical practitioners and, unless well organized, may provide hurried and impersonal service.

(11) *Private office practice in hospitals.* Data accumulated by the Council on Medical Education and Hospitals indicate that in 1931 nearly 1000 hospitals were used to some degree by 4500 physicians who maintained offices or office hours for private ambulatory patients in the institutions.

(12) *Public health nursing.* One of the most significant tendencies of the past quarter-century has been the development of public health nursing, under both official and non-official auspices. The visiting nurse, originally employed to care for the sick in the home, has broadened her scope to include *health teaching* as a major objective; so that public health nursing is now defined as an organized community service rendered by graduate nurses to the individual, the family and the community.

The outstanding advantages of public health nursing are that it makes a limited amount of nursing service available to many families who cannot afford to employ full-time nurses or who need only occasional nursing, and it offers an excellent opportunity for health instruction of families by example as well as by precept.

(13) *Organized service by trained nurse-midwives.* About 15% of the child-births in this country are attended by midwives. In 1925, approximately 300,000 births were cared for by such practitioners, most of whom are untrained, dirty, and superstitious. In contrast to them, are a few trained nurse-midwives who handle normal obstetric cases very

effectively. The best known example of the use of trained nurse-midwives in this country is in the Frontier Nursing Service of Kentucky, whose nurses delivered 818 patients during the 6 years ending May 1, 1931, with only 1 maternal death.

(14) *Trained Nurse-Attendants.* In Boston, Detroit, and Brattleboro, Vermont, women have been trained as "nurse-attendants", to do simple home nursing under the direction of trained public health nurses and, in addition, to perform necessary house work. Charges for such services are somewhat lower than those customarily made by trained nurses.

(15) *Expansion of governmental health services.* Local and state governments have long provided treatment for infectious diseases, especially for tuberculosis, for mental diseases and, more recently, for venereal diseases.

Since the first law which provided for medical inspection of school children was passed by Connecticut in 1899, there has been a rapid and substantial growth in school health service in both elementary and high schools. Most of the work for school children is preventive and diagnostic: medical inspection by school physicians, dentists, nurses, and teachers; examination of children returning to school after illness; examination of children about to enter school; and instruction in diet and hygiene. In some school systems, however, certain curative services are also provided, such as the removal of diseased tonsils or adenoids, the filling of dental cavities, the provision of eyeglasses, and the treatment of mental maladjustments.

(16) *Government provision of hospitalization.* Cities and counties have for a long time provided hospitals for the care of the indigent. In recent years some local governments have experimented with the plan of providing hospitalization at moderate rates to *all* classes of the population. Both Cincinnati and Buffalo have large general hospitals open under certain restrictions, to all residents.

The advantage of governmental aid in the provision of hospital service is that it enables hospitals to render service at lower charges and thereby assists patients in meeting the costs of hospitalized illnesses, which include about 50% of the total costs of all medical service. In some areas, tax funds must be used if hospital service of any kind is to be provided. If state, city, or county aid is given to non-governmental hospitals, the governmental agency can set minimum standards for hospital administration and practice.

On the other hand, since hospital service is only one aspect of medical care, this plan does not solve the problem of providing satisfactory medical service to all who need it. Furthermore, many persons hesitate to approve governmental provision or support of hospitalization, because they believe that governmental effort, more frequently than comparable private effort is associated with waste, extravagance, and incompetence.

(17) *Tax-supported physicians in rural areas.* In 30 or more rural "municipalities" of Saskatchewan, one or more physicians have been employed to provide medical service. About 2/3 of the physicians are on a whole-time basis. These physicians are usually also appointed local health officers. The cost of their services, paid through tax funds, is about $7.50 to $10 per family per year.

This system, which was started about 1921, provides physicians with incomes and favorable working conditions and assures their services to many communities which otherwise would not have resident physicians. The costs are so distributed that no individual patients or families are heavily burdened. Early consultation is encouraged, yet there is little tendency among patients to take up the doctor's time for trifling ailments. Preventive measures are utilized freely. Some of the doctors say that their relations with patients are more cordial than when a fee was charged for each service, and, they are saved much financial worry and clerical detail. No community in Saskatchewan which has adopted the "municipal doctor" plan has abandoned it.

(18) *State aid for local medical service.* Several states have found that adequate local public health service probably will not be provided without state financial assistance. One state, New York, has authorized the State Department of Health to reimburse any county

to the extent of ½ its expenditures for the construction, establishment, or maintenance "of a county, community or other public hospital, clinic, or dispensary or similar institution", or "any public enterprise or activity for the improvement of the public health", provided the enterprise is approved by the State Department of Health. In spite of the broad terms of the act, most of the money so far appropriated under it has been for the support of public health activities, and relatively little for direct medical and hospital services.

(19) *Insurance for hospitalized illnesses.* Several plans have been tried for assisting patients in meeting the costs of the more expensive illnesses. Some of these, such as the hospital insurance offered by the Baylor University Hospital of Dallas, Texas, and by the Community Hospital of Grinnell, Iowa, cover only the cost of hospitalization. In these plans, the hospital deals with organized groups of persons who pay a fixed amount per year into a common fund out of which their hospital bills are met.

(20) *University medical services.* Since student health departments were started as early as 1860, experience with this type of service has been extensive. On January 1, 1931, there were 153 colleges or universities with organized divisional student health services. Many of these provided a complete medical service at costs of $9 to $30 per capita, per school year. At the University of California, physicians' services, dentistry, hospitalization, laboratory service, physiotherapy, x-ray service, and drugs are furnished to 9800 students in residence at a cost, including capital charges, of $17.86 *per capita* for the school year.

(21) *Health, hospital, and nursing councils.* There are in the United States at least a dozen health councils, the oldest of which was formed in 1917. The Cleveland Health Council, which may be considered representative, acts as a coöperative agency to coördinate public health work.

(22) *Periodic payment plans of group clinics.* At least a dozen private group clinics now provide medical service to groups of persons for periodic payments. Usually these plans are worked out at the suggestion of and in coöperation with consumer groups. The Ross-Loos Clinic in Los Angeles, for example, at the request of a group of employees, began about 3 years ago to offer medical service complete except for dentistry and nursing, to several such groups. The number of subscribers has grown steadily, and includes at present about 9000 persons who pay $2 per person, per month.

It has all the *advantages* of industrial medical service and, in addition, control of medical service is in the hands of the practitioners who direct the clinic, while the formation of policies is shared by representatives of the patients.

The most important *disadvantage* of this service, as at present operated, is that there is an increased opportunity for clinics to engage in competition as to price, which is disastrous to professional standards and therefore to the welfare of patients.

Plans: (23) *Installment payments through loan companies;* (24) *"Health Insurance" provided by insurance companies;* and (25) *Medical benefit corporations operating for profit;* have little to commend them, and need not be now described.

European Developments in the Provision of Medical Care

In Europe, as in the United States, the provision of medical service is mainly in the hands of individual practitioners although hospitals are well developed and, in some localities, clinics and other forms of group practice provide medical care in conjunction with group payment by insurance or taxation.

In most countries of Europe, every employed person earning less than a specified income is legally compelled to insure himself against sickness, and the insurance fund to which he belongs must in return provide him with certain medical services.

The British system requires all employed persons earning less than £250 annually to insure, and furnishes cash benefits together with the services of general medical practitioners and such medicines as they prescribe. Hospitalization, dentistry, the services of specialists, and the medical care of dependents

are not included, although dental care has not infrequently been added by voluntary local action. The British Medical Association opposed the insurance scheme at its inception in 1911 but has now officially recognized its benefits and advocates an extension of the scope of service and the inclusion of dependents. In Great Britain, every physician may undertake insurance practice if he wishes and he is remunerated at a fixed amount per patient per year. Free choice of physicians among those wishing to accept insurance practice is assured.

Germany passed its first compulsory health insurance law in 1883. It applied only to certain industries in which voluntary insurance had already developed. Succeeding legislation has greatly extended the system both in the number of persons served and in the range of benefits provided, so that now almost 2/3 of the entire population are covered. Since the War, voluntary insurance has been extending rapidly among persons who are above the economic limit of the compulsory insurance system.

France introduced compulsory health insurance only in 1930, providing medical and cash benefit for persons whose income does not exceed 18,000 francs. Russia under the Soviet régime is the only country in Europe which has undertaken state medicine, with medical services and facilities provided and administered by the government. Denmark, which with Sweden depends on voluntary insurance, has brought the majority of the population under the system. In Denmark the individual is not legally required to insure against sickness, but he has many indirect incentives to join and faces certain legal disadvantages if he does not.

CHAPTER V

The Recommendations of the Committee

The plan for satisfactory medical service outlined in Chapter III can best be attained, the Committee believes, by a process of evolution. The growth should come mainly from existing institutions and organizations. In fulfillment of its accepted responsibilities, the Committee states in this Chapter its concrete recommendations for the attainment of satisfactory medical service. Before it presents specific steps, however, the Committee states its philosophy and intent in preparing its recommendations.

The Philosophy and Intent of the Recommendations

The Committee approached its task of formulating recommendations with substantial agreement on the following:

The problem of providing satisfactory medical service to the people of the United States at costs within their means is one of paramount importance. Its solution would be of immense economic and social significance.

The problem is complicated and differs from one region to another. No panacea is available: no solution is applicable today to all areas of the country. In 1930 the population of the continental United States was so distributed that 45% lived in cities or metropolitan areas, containing at least 100,000 persons.

Among our population groups there are wide variations in cultural attainment and in standards of living; and there are wide variations in the kind of medical service demanded. Although in every case the service should be scientific, some groups of the population expect refinements not as yet demanded or appreciated by others. Thus there are also wide variations in the costs of the service. No single plan, therefore, is adaptable to all of America's regional variations.

The recommendations vary in importance, in scope, and in immediate applicability. Some are applicable only to urban areas; others only partially solve the problem. Some of the recommendations could be applied immediately, whereas others must await further evolution of medical practice and the development of an informed public opinion. The Committee believes that its obligations require it to think ahead for 20 or 30 years, as well as for the next 5 or 10 years, and to present distant as well as immediate goals.

An evolutionary process is now going on in medical practice and in the relationships be

tween medical science and medical practice. This process is greatly influenced by rapidly changing economic and social conditions. Serviceable recommendations must be in line with existing trends. The most fundamental of the Committee's recommendations grow out of American experience and together constitute a plan which appears superior in certain respects to existing plans in other countries.

The Committee does not propose the immediate adoption of programs which involve sudden large increases in expenditures from public or private funds.

The interests of the 1,100,000 persons in the United States who furnish medical service and the 123,000,000 who receive it are closely interwoven. The professional standards of physicians, dentists, nurses, pharmacists, hospitals, and other practitioners and agencies which furnish medical care must be carefully guarded in behalf of the people served, as well as in behalf of those who provide service.

The Committee is not dogmatic in its recommendations. They are based on the study of certain groups of facts which have revealed needs or which give ground for believing that methods tested in some undertakings will be of benefit if wisely applied on a larger scale. Opportunities exist for trying out many plans under various and variable conditions. Where action can be limited to the city or county, we have several thousand experiment stations. If state action is necessary, there are 48 laboratories.

The Committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results. Experimentation, however, will be significant only if it is conducted in such a way that its results can be analyzed and made available.

With these considerations in mind, the Committee presents its recommendations. The basic recommendations are few and simple; they seem to the Committee eminently reasonable. All are interrelated, and specific steps are proposed for putting them into effect.

CHAPTER VI

The Challenge of the Future

During the last half century most of the great plagues, which formerly had devastated nations, have disappeared from all civilized communities. The general death rate, with its accompaniment of suffering and crippling and economic waste, has been strikingly reduced—by nearly 50% in the large cities of this country. Such simple forms of magic as the filtration of water and the pasteurization of milk have exorcised the demons of cholera and typhoid fever. Malaria and hookworm disease are steadily giving ground, and the fear of diphtheria has been largely allayed. New knowledge of nutrition is yielding remarkable results in the treatment and prevention of many deficiency diseases.

Yet, as we survey the whole battle-field of the war between man and disease, we are struck by the fact that our victories have been attained only in certain sectors, while in others the enemy is holding his own or is even advancing. While reductions in the death rates from infant diseases, diphtheria, tuberculosis, typhoid fever, and other causes have resulted in an increase in the length of life, *there remains a vast amount of preventable disease that is not prevented.* Our failures result not only from insufficient scientific knowledge and from human weakness, but also from our failure to utilize existing knowledge, equipment, and personnel.

The successes of modern medicine have been achieved for the most part in those fields in which knowledge, equipment, and personnel have been organized under community leadership. Thus, we have made concerted efforts to control infant mortality, tuberculosis, and the acute communicable diseases, and in large measure we have succeeded. Some disorders, on the other hand, have been left to the initiative of the private practitioner and the individual citizen with disappointing, and sometimes negligible, results.

There is abundant evidence that the people of the United States are ready to enlist in such a warfare. News-papers and magazines are contributing a vast amount of subject mat-

RECOMMENDATIONS OF THE COMMITTEE

(Majority Report)

I

The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician.

II

The Committee recommends the extension of all basic public health services—whether provided by governmental or non-governmental agencies—so that they will be available to the entire population according to its needs. This extension requires primarily increased financial support for official health departments and full-time trained health officers and members of their staffs whose tenure is dependent only upon professional and administrative competence.

III

The Committee recommends that the costs of medical care be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods. This is not meant to preclude the continuation of medical service provided on an individual fee basis for those who prefer the present method. Cash benefits, *i. e.*, compensation for wage-loss due to illness, if and when provided, should be separate and distinct from medical services.

IV

The Committee recommends that the study, evaluation, and coördination of medical service be considered important functions for every state and local community; that agencies be formed to exercise these functions; and that the coördination of rural with urban services receive special attention.

V

The Committee makes the following recommendations in the field of professional education: (1) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that post-graduate educational opportunities be increased; (2) that dental students be given a broader educational background; (3) that pharmaceutic education place more stress on the pharmacist's responsibilities and opportunities for public service; (4) that nursing education be thoroughly remoulded to provide well-educated and well-qualified registered nurses; (5) that less thoroughly trained but competent nursing aides and attendants be provided; (6) that adequate training for nurse-midwives be provided; and (7) that opportunities be offered for the systematic training of hospital and clinic administrators.

ter on the promotion of health. Commercial enterprises are exploiting the interest of the people in the improvement of their health. Women's clubs and business men's organizations have assumed leadership in the attack on various disease problems. As one result of their work, thousands of crippled children have been provided with corrective treatment.

The outstanding need is for effective leadership. Wars are not won without it. In each local community, a representative body is needed to conduct a militant program over a period of years. This body in most instances may well be a local coördinating agency, such as the Committee has recommended. A few communities may prefer to increase the responsibility of health departments and accept their leadership. Each community must decide for itself what type of leadership promises to be most effective.

Whatever may be the nature of the group which the local community accepts for leadership, its effectiveness will depend largely upon an extensive knowledge and an unbiased attitude in regard to the existing situation. Obviously, there must be continued study of the diseases and conditions which are responsible for sickness and disability, as well as a survey of all of the agencies, groups, and individuals which provide medical service. Private medical practice and public health work are so closely related that, in such a survey, it is folly to deal with them separately.

With the necessary information available,

RECOMMENDATIONS OF THE MINORITY GROUP

(Minority Report)

I

The Minority recommends that government competition in the practice of medicine be discontinued and that its activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health; (c) to the support of the medical departments of the Army and Navy, Coast and Geodetic Survey, and other government services which cannot, because of their nature or location, be served by the general medical profession; and (d) to the care of veterans suffering from *bona fide* service-connected disabilities and diseases except in the case of tuberculosis and nervous and mental diseases.

II

The Minority recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden.

III

The Minority joins with the Committee in recommending that the study, evaluation, and coördination of medical service be considered important functions for every state and local community; that agencies be formed to exercise these functions; and that the coördination of rural with urban services receive special attention.

IV

The Minority recommends that united attempts be made to restore the general practitioner to the central place in medical practice.

V

The Minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession.

VI

The Minority recommends that methods which can rightly be fitted into our present institutions and agencies be given careful trial without interfering with the fundamentals of medical practice.

VII

The Minority recommends the development by state or county medical societies of plans for medical care.

the local community is ready for action. The agency which assumes leadership in the development of a program will consider carefully, it is hoped, the recommendations of the Committee on the Costs of Medical Care. *These recommendations are flexible and adaptable.* But they do not exhaust the possibilities. The future is pregnant with opportunity, but each community must determine, through careful study, what kind of program is best adapted to its own particular needs.

In the various states, as in local communities, leadership may be assumed by a militant, state coördinating agency: by the *State Medical Society,* by the state department of health, or by some other agency. Here, also, the facts are essential as a basis for intelligent action. The state will not find a detailed program in the recommendations of the Committee, but *must work out its own plan based on its own needs.*

The coöperation of the professional groups in community or state leadership is essential. Their stake in these issues is very large; their interest is continuing. They should instigate as well as guide. The crucial point in the generalship of the forces at work is, perhaps, the development of a proper relation between the professional and the lay groups. *The public should recognize the central place of the professional groups in determining standards and methods. The professions should recognize their ultimate responsibilities to the public.* The control of undesirable commercial enterprises in this field will depend largely on the watchfulness of the professional bodies, on their ability to enlist lay coöperation, and on the development of sound and successfully operating non-commercial plans.

Whatever means may be employed, the time has come for action. European countries may not have proceeded with the greatest wisdom, but they have acted. Most of them have developed organized systems of medical care.

We in the United States, above all other countries, are now in a position to go forward intelligently.

Delay can no longer be tolerated. By early application of the knowledge we now possess, we could soon double the number of patients cured of cancer, and we could markedly reduce the high death rates still pertaining in several other diseases. Thousands of people are sick and dying daily in this country—*because the knowledge and facilities that we have are inadequately applied.* We must promptly put this knowledge and these facilities to work.

Statement by Minority Group

(As a preliminary to that "statement", permit us to make an explanation. The first 4 Chapters of the published Report of the Committee on the Costs of Medical Care, dealt with the general problem under consideration: Chapter I outlined the present status of medical care. Chapter II set forth the factors or elements essential to any satisfactory program. Chapter III presented the whole Committee's concept of the ideal, ultimate objective. Chapter IV described plans now being tried, or which might be used experimentally, with a view to improving conditions and attaining the goal. Chapter V presented specific recommendations, for consideration by the organized medical profession, as to action that should be taken; but, at that point, perfect harmony halted; the *recommendations referred to* being signed by a *majority*—but not by all—of the committee members (36 out of 48). Chapter VI states the need for action and explains *why*, and to a limited extent *how*, practical steps should now be taken by the medical profession.

Because of the *halt* previously mentioned, and the "Parting of the ways" which followed —a *Minority Report* became necessary, and we now present, in abstract form, the general statement comprising that report; the *Minority's Recommendations* having been transferred to another part of our record in order that they might accompany the *Majority's Recommendations* for the convenience of our readers who will wish to make comparisons.

Among the 48 members composing the Committee, there were 25 Doctors of Medicine; i. e. having the Degree M.D. We understand that the *regular* Committee Report (the now so-called Majority Report) included among its 36 signers, 17 out of the 25 physicians; while the other 8 physicians and 1 layman signed the chief Minority Report.

The 8 physicians whose names are attached to the following statement, were: Drs. A. C. Christie, George E. Follansbee, M. L. Harris, Kerby S. Howlett, A. C. Morgan, Olin West, Robert Wilson; and N. B. Van Etten.—Ed.)

The minority group of the Committee whose names are subscribed to this report are in accord with the majority in many of their conclusions and recommendations. We find ourselves, however, in conflict with what we conceive to be the general tone or trend of the report and, in certain instances, in sharp disagreement with the recommendations for future action. We have also certain constructive suggestions to make which have been omitted, or the importance of which has not been sufficiently emphasized, in the report of the majority. We regret the necessity for a minority report, but we are convinced that we would fail in our duty both to the public and to the medical profession if we did not point out as forcibly as possible what we conceive to be unwise recommendations or omissions in the majority report of this Committee.

We are in full and hearty accord with the majority in its recommendations for "The Strengthening of Public Health Services" and "Basic Educational Improvements"; and we agree to some extent with the pronouncements of the Committee in respect to coördination of medical services. The first effect of "strengthening public health services" will be a considerable increase in the total cost of medical care, but we have the hope that eventually great savings will come from decreases in the incidence and duration of certain diseases.

Some of the recommendations for coördination of medical services and for basic improvements in medical education are immediately practicable and will undoubtedly result in reductions in the costs of medical care. They

are in line with the general progress of medicine and are based on sound experience. Many educational improvements are under way through the initiative of the medical and dental professions and college authorities. Among them one of the most important is the increasing emphasis upon the necessity for more thorough training of the general practitioner in all of those fields which only he can adequately fill. In this connection, we call attention to the fact that neither scientific medicine nor the organized professions have been unprogressive. They have assumed initiative and have maintained leadership in the advancement of scientific knowledge and in improving the methods of its application to human welfare.

In the opinion of the minority, the general trend of the majority report makes it appear that the medical profession has been static and unprogressive. This implication we believe to be unjustified by the history of medical progress.

We are in sympathy with the recommendations of the majority which deal with the better training of specialists and their proper control. This is another matter in which the medical profession has taken the initiative. There are already several organizations for the certification of specialists. It should be remembered that specialism has made great contributions to medical progress. Its abuses are capable of control by the profession without any revolutionary changes.

We repeat that this minority is heartily in accord with the majority recommendations with respect to public health and progress in medical education.

With regard to the majority Recommendations 1 and 3, dealing with "Organization of Medical Services" and "Group Payment for Medical Service", the convictions of this minority are so divergent from those of the majority that they must be discussed in detail.

Organization of Medical Services

The minority group recognizes the desirability of better correlation of the activities of the professions and it is in agreement with the majority upon some of the suggestions under the above heading. There is nothing, however, in the facts elicited by the Committee nor in the general experience of the medical professions to lead us to believe that "organization" can accomplish what is claimed for it in the majority report. On the contrary, it seems clear to us that many of the methods advocated will give rise to new and greater evils in the attempt to cure existing ones. Our views are set forth below under each heading of the majority report.

Community Medical Centers. The emphasis placed upon this plan which is called "the Committee's most fundamental specific proposal" we believe to be far beyond any possibility of its ultimate value. It is admittedly an idealistic plan based almost solely upon theory. There is nothing in experience to show that it is a workable scheme or that it would not contain evils of its own which would be worse than those it is supposed to alleviate. Above all, *there is no evidence to prove that it would accomplish what ought to be the first object of this Committee—the lessening of the costs of medical care.* The plan is suggestive of the great mergers in industry, the main medical center being in the nature of the parent holding company governing the activities of subsidiaries and branches. The idea that size and power are synonymous with excellence and efficiency has received some severe blows during the current economic depression, and opinions concerning it are undergoing revision.

The medical center plan is the adoption by medicine of the technic of big business; that is, mass production. It seems almost impossible for those who are not engaged in the practice of medicine to understand that *the profession of medicine is a personal service and cannot adopt mass production methods without changing its character.* It is always the individual patient who requires medical care, not diseases or economic classes or groups. The neglect of this principle in other fields has brought serious evils that are now being corrected only with great difficulty. When mass operation revolutionized industry, social movements tended to follow the industrial pattern. Even education took on many of the

factory forms. Educators, social workers, and penologists are now all emphasizing the value of individual case work. Yet, in none of these fields are the problems so intensely personal and individual as in that of medical diagnosis and treatment. Nowhere is there greater need of complete liberty of action and close continuous knowledge of the person to be treated, nor greater necessity for confidence, than in the relation between patient and physician. *Extensive plans are being perfected by some State Medical Societies and by the American Medical Association looking to establishment of control of specialism.*

Among the many objections to the medical center plan which must occur to anyone familiar with the requirements of medical practice, are the following: (1) It would establish a medical hierarchy in every community to dictate who might practice medicine there. This is inherent in the plan since any new member of the center must be chosen either by the chief or by a small staff. (2) It would be impossible to prevent competition among the many such centers necessary for large cities; cost would inevitably be increased by the organization necessary to assign patients to the various centers. This would add to the evils of medical dictatorship those of a new bureau in the local government with its attendant cost. (3) Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions.

We look upon this plan as far-fetched and visionary. It has no practical relationship to the question the Committee has set itself to solve. Placed as it is, at the very beginning of the Committee's recommendations, it must create a doubt of the Committee's grasp of the problem to which it has addressed itself. It seems to us an illustration of what is almost an obsession with many people, namely that "organization" can cure most, if not all, human ills.

Industrial Medical Service. It is our opinion that this question, which is of great importance, has not been adequately nor fairly dealt with in the majority report. The publications of the Committee which describe existing industrial medical services fail, in our opinion, to give a true picture of conditions as they exist throughout the country. For each of these favorable reports many instances could be cited of industrial medical services where the results have been exceedingly unfavorable. These are types of "contract practice" which have been a source of controversy for many years. The Judicial Council of the American Medical Association defines "contract practice" as follows:

"By the term 'contract practice' as applied to medicine, is meant the carrying out of an agreement between a physician or group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita."

It should be remembered that the medical profession does not object to contract practice *per se* but only to the unethical practices which may attend that method of rendering medical services. There are numerous conditions under which it may be ethical for physicians to enter into contracts to furnish medical care. In isolated mining or lumbering camps medical service can be had only by entering into contract with some physician. Under workmen's compensation laws in some states employers and insurance companies are compelled to provide medical care in such a way that it can be secured only by some form of contract. This came about because workmen's compensation laws in most states were written without regard to the character of medical service under such laws. Defects in the laws are gradually being corrected to provide for a better quality of medical service. Another type of contract practice which cannot be considered unethical is that in isolated communities or sparsely settled rural districts where medical service can be secured only by contracting with a physician to pay part or all of his compensation.

Contracts must be considered unethical and injurious both to the public and to the physician when any of the following features prevail: (1) When there is solicitation of patients, either directly or indirectly. (2) When there is competition and under-bidding to se-

cure the contract. (3) When the compensation is inadequate to secure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of physicians is prevented. (6) When the contract because of any of its provisions of practical results is contrary to sound public policy.

One of the strongest objections to industrial medical services, mutual benefit associations, so-called health and hospital associations, and other forms of contract practice, is—that there has been no means of preventing destructive competition between individuals or groups concerned with these movements. *This injects a type of commercialism into medical practice which is harmful to the public and the medical profession and results in an inferior quality of medical service.*

One of the pernicious effects of contract practice scheme is that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practice, but as new ones are formed the barriers are gradually broken down in order to secure business.

There are general objections to all such methods of furnishing medical care which have been pointed out by representatives of organized labor. They are essentially paternalistic in their operation, giving to the management of industries an increased control over their employees. The intrusion of the company employed doctor into intimate family relationships is objectionable. *Privacy and the personal relationship which should exist between patient and physician are broken down. The records of the patient's illness are in the files at the disposal of the company officials. Free choice of physician is absent; coercion is inevitable. Fear of loss of his job compels the employee's consent to the plan and to the doctor furnished by the company.*

It is the belief of the minority group that the majority report has presented this entire question in a distorted manner. The evils of contract practice are widespread and pernicious. The studies published by the Committee show only the favorable aspects. They were selected because they were considered the most favorable examples of this type of practice in the United States. For each of these plans a score of the opposite kind can be found. The evils are inherent in the system although they may be minimized when a high grade personnel is found either among employees or medical group, or both.

Utilization of Subsidiary Personnel. This recommendation is nothing new in medical practice. It has already developed along many lines through the initiative of the medical, dental, and nursing professions. We need cite only the widespread employment of technicians in clinical laboratories, the use of dental technicians and hygienists both for laboratory and clinical work, and the extension of nursing service. In radiologic departments in hospitals, clinics, and private practice important duties have been assigned to technicians, and their services are being widely utilized. Even in those fields specifically mentioned by the majority report there have already occurred many advances in the directions recommended. We wish to add a word of caution relative to the dangers involved in permitting non-medical technicians to assume the duties which ony physicians should undertake. There is constant temptation in many fields to permit technicians to perform duties entirely unjustified by their knowledge and training. Deterioration of service invariably results from such practice.

Private Group Clinics. We believe the establishment of such clinics is in line of progress when they are a natural outgrowth of local conditions. It is the belief of the minority group that the majority report gives far too much importance to the value of this type of medical practice. That it has accomplished generally, or can ever accomplish, what is there claimed for it is open to grave doubt. *There is nothing in our own experience, nor have we been able to find anything in the Committee's studies, to lead us to conclude that group practice can furnish in general better or cheaper medical care than we have at present.* In cities above 100,000 in population the multiplication of groups results in duplication

of laboratories, expensive equipment, and overhead charges which make the system not less but more expensive than the present method. It usually results not in fewer specialists but more, because each group feels that it must have a representative of each important specialty. Even if it were possible to preserve the personal relationship of physician and patient in group practice, which is admittedly difficult, the method has only limited applicability. We wish to call attention to the fact that the studies published by the Committee, on "Private Group Clinics", were far too few in number to constitute a safe base upon which to erect so large a structure as is proposed. This is especially true since no evidence is produced to indicate lower costs to patients. The studies of the Committee which show 40% overhead in the practice of private physicians, and 15 to 25% for groups, fail to tell the whole story. It must be remembered that groups usually offer only partial service and that when full domiciliary care is offered it is often provided through young and inexperienced doctors on a low salary. Costs can always be reduced through a restricted or inferior service. The most important discrepancy in conclusions drawn from the above studies arises from failure to consider the fact that multiplication of clinics or groups in large communities results in provision of expensive equipment far beyond the needs of the community. It serves no good purpose to reduce overhead in individual clinics if the total cost to the community is increased through duplication of plants.

The establishment of groups within recent years in many cities throughout the United States to treat patients under workmen's compensation laws or under contracts made with employers or groups of laymen has resulted in many abuses. Such groups are now in competition with each other, many of them openly soliciting patients through paid agents; many of them controlled by laymen and most of them constantly trying to keep down the cost of operation by employing physicians of inferior ability. Such groups, now scattered all over the United States, are rapidly resulting in the commercialization of medicine and the destruction of professional standards. Under such a system the tendency is to reduce medicine to the status of a competitive business instead of a profession with high ethical standards.

It is not our contention that all group practice has the above results but only that many groups have already been formed to practice under the commercial arrangements indicated. It is important in judging this question to give attention not only to those successful and favorable experiments in group practice cited in the majority report but also to take account of the scores of clinics which have failed and of the large numbers which are at present engaged in a type of practice inimical to every fine tradition of medicine.

Other Disadvantages to the Physician in Group Practice. Except for the heads of the group, freedom of action is restricted in respect to vacations, study, travel, attendance upon scientific meetings, and even publication of medical articles, by the will of the chief or chiefs of the clinic. It is contended by proponents of group practice that the physician can advance in professional knowledge more rapidly if he is assured of opportunities for study and is relieved of financial worries by the group, than is possible in private practice. It was pointed out above that only the chiefs of a clinic have freedom to advance along lines of their own choice. Subordinates are not permitted to pursue any course contrary to the general policies of the clinic. It is also very doubtful if men placed on a secure financial footing by a group contribute any more to progress than do those who are impelled to their best work under the stimulation of individual competition, scientific ambition, and initiative. The income of members of a group, except that of the owner or owners, while fairly stable, is comparatively static. When a salaried employee advances in salary to a point no longer profitable to the clinic, his income remains fixed. He then has the choice of waiting until someone ahead of him, whose place he can fill, dies, or of leaving the clinic and starting to build a practice at a time when he should be reaping the rewards of experience and ability.

The plans advocated in the majority report, involving groups made up of general practitioners and specialists, are theoretically attractive but thoroughly impractical. We are still far away from the time when the general practitioner will be accepted by a group of specialists as the correlator of their work.

We wish to make it clear that the above discussion of group practice does not refer to the association of physicians upon the staffs of hospitals nor their contact and consultation in clinics.

It should be remembered that medical groups are subject to financial failure, just as are other business ventures. This has happened repeatedly and is not prevented by having a lay business manager in charge of finances. A frequent cause of failure and disruption of clinics or groups, is the death or disability of some able man or men about whom the clinic has been built. When a group is forced to disband, the physicians must seek employment in some other group or attempt private practice. The latter is usually very difficult because men in a group usually have little personal following and may have little training to practice general medicine. It should be remembered that patients who go to a clinic are the patients of the clinic and not of any individual doctor. Failure of a group may also have a very injurious effect upon the medical care of the community which has become dependent upon it. The private practice of medicine is likely to be a much more stable system, year in and year out, than any system based upon groups.

The minority recognizes the advantage of group practice under certain conditions. *It does not, however, believe that group practice offers any real solution to the problems of the cost of medical care except under very restricted conditions.*

Pay Clinics. We approve the development of pay clinics when they are under the management and control of physicians, are conducted on a high ethical plane, are needed to meet a situation. The same ethical considerations should prevail in the relations of clinic and patient as are operative between the private physician and his patient. There is no magic in the name *clinic* that can make it ethical for its agents to solicit patients in its name when it is considered unethical for a physician to do so as an individual. The traditions of the medical profession are strongly opposed to advertising and to solicitation of patients.

When clinics are owned and controlled by laymen, the evils are accentuated. Clinics so owned or controlled result in the exploitation of the public and the medical professions. and in an inferior quality of medical service or an increase in the costs of medical care, or both. When the middleman enters into the picture, the costs of medical care are always increased and quality is sacrificed. This is true whether the middleman is a layman or a corporation running a clinic, or an insurance company which must charge costs of operation to the patient.

County Medical Society Clinics. The subject is dismissed in the majority report as of little or no importance. The minority believes that this is an important development which may be very valuable in solving the problems of medical care. We discuss it among other specific constructive suggestions offered later.

Group Payment for Medical Service

Nothing has been made clearer than the fact that *voluntary* health insurance schemes have everywhere failed. In Europe they have been replaced by compulsory systems which are now under trial. Even in Denmark, where the system is nominally voluntary, there are indirect but effective means of compulsion.

It seems clear that recommendations for further trial and expansion of voluntary insurance schemes in the United States are entirely inconsistent with the Committee's own findings. To recommend that our own country again experiment with discredited methods of voluntary insurance is simply to ignore all that has been learned by costly experience in many other countries as well as in our own.

It seems clear, then, that if we must adopt in this country either of the methods tried out in Europe, the sensible and logical plan would be to adopt the method to which European countries have come through experience,

that is, a compulsory plan under governmental control.

The statement that most of the physicians in England prefer not to go back to the system under which they practiced before is not convincing because the system under which they practiced before was one of widespread voluntary insurance.

The objections to compulsory health insurance are almost as compelling to this minority group as are those to voluntary insurance. The operation of every form of insurance practice up to the present time has resulted in a vast amount of competitive effort on the part of practitioner groups, hospitals, and lay controlled organizations. Such competition tends to lower the standards of medical care, degrade the medical personnel, and make medical care a business rather than a profession. Proof of this is at hand in our own experience in this country with the only compulsory system with which we have yet had to deal, workmen's compensation insurance.

It is our conviction that the Committee on the Costs of Medical Care would have served its stated purposes and the cause of medical progress and the people's health much better if it had taken a strong stand against all of those methods of caring for the sick which have in them the dangers and evils of "contract practice". By doing so they would have come to the assistance of the medical profession in a battle against forces which threaten to destroy its ideals, disrupt its organizations and completely commercialize its practice, and which are at the same time opposed to the public welfare. The medical profession is now in many parts of the country extending and perfecting plans through which it can offer to the people in a more systematic way the services of *all* the physicians of each community at prices which all the people can afford. It is only by including *all* of the members of the medical profession of a community that the abuses under insurance systems may be avoided.

Recommendations of the minority. The minority group, in offering its recommendations, has tried to keep in mind the main object which called this Committee together; namely, to find some solution for the problem of furnishing good medical care to all the people at prices which they can afford. We have no delusions that our recommendations, even if fully put into effect, will solve all the problems of medical care. We have tried to approach the problem from a practical standpoint and to suggest progressive changes in the present system rather than to offer new methods based largely on theory and revolutionary in their practical application. We are not opposed to progress nor to the adoption of new procedures. We are especially concerned, however, that new procedures be based upon sound experience and that in adopting them we do not lose the values that have been accumulated through the centuries. It is true in medicine as in all other fields of human experience that the soundest and most lasting progress is brought about slowly and step by step. Medical practice in the United States is progressing in this manner. We believe this to be the truly scientific method.

It has been stated in the majority report of this Committee that we must plan 20 to 50 years in advance. We doubt our wisdom to do this. If society changes as rapidly in the next 50 years as in the past 50, it seems presumptuous to assume that we can foresee conditions or needs sufficiently clearly to plan so far in advance.

Our recommendations are based upon the conviction that the medical profession is the essential element in the furnishing of medical care. Its influence should be upheld and strengthened and every assistance given to it to maintain its high professional standards. They are based upon the further conviction that the general practitioner is the most important factor in the medical profession and that he can function effectively only through the maintenance of private medical practice.

Development by State or County Medical Societies of Plans for Medical Care. The recommendations we have offered up to this point are concerned with the elimination of waste, the abatement or avoidance of evident evils in present practice, and improvement in the quality of medical care. We have already set forth our objections to the majority's rec-

ommendations for adoption of insurance systems. We tried to make it plain that we are not opposed to insurance but only to the abuses and evils that have practically always accompanied insurance medicine.

Medical societies in various parts of the United States have been giving careful study to the question of the possibility of distributing the costs of medical care and at the same time avoiding the evils of insurance systems.

This minority group agrees that any plan for the distribution of medical costs must have the following safeguards:

(1) It must be under the control of the medical profession; but a "Grievance Board" to settle disputes, having lay representation, is permissible and desirable.

(2) It must guarantee not only nominal but actual free choice of physician.

(3) It must include all, or a large majority of, the members of the County Medical Society.

(4) The funds must be administered on a non-profit basis.

(5) It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

(6) It should make adequate provision for community care of the indigent.

(7) It must be entirely separate from any plan providing for cash benefits.

(8) It must not require certification of disability by the physician treating the patient.

This group recognizes the value of plans based upon the above principles by County Medical Societies. We believe that the component county group of physicians is the proper unit of organization to attempt such experiments. Our reasons for favoring thorough trial of the County Society plan for furnishing complete medical care are as follows:

(1) It places responsibility for the medical care of the entire community upon the organized physicians of the community.

(2) It places medical care under the control of the organized profession instead of in the hands of lay-corporations, insurance companies, etc.

(3) It places responsibiity for the quality of service directly upon the organized profession. It is in fact the only plan which guarantees quality of service and makes it the only basis of competition.

(4) It removes the possibility of unethical competition because it includes all the physicians of the community and fixes a fee schedule.

(5) Solicitation of patients, under-bidding for contracts and other evils of the usual insurance plans are eliminated.

(6) Freedom of choice of physician is assured and the essential personal relationship of physician and patient is thereby preserved.

(7) It is the only plan which includes all classes, from the indigent to the wealthy.

(8) It is adaptable to every locality, both urban and rural.

(9) It provides for a minimum cost of administration by operating on a non-profit basis.

(10) It provides for payment, by every patient with income, of a certain minimum amount before the insurance is in operation. The minimum rises with the patient's income. This provision alone will operate to avoid many abuses in all other types of insurance practice.

(11) It provides for means of certification of disability separate from the attending physician.

(12) Cash benefits do not form a part of the plan.

The main objections urged against the plan are that it places too much power in the hands of the organized medical profession, and that county medical organizations will be too lethargic to put the plan into operation.

It is the opinion of this group that it is much better to lodge power in the hands of the professions which are trained to furnish medical care than in the hands of lay corporations.

Conclusion. The problem of the payment of the various expenses that accompany disease and injury has arisen as a result of developments in the medical field, on the one hand, and of complex changes in the economic and social order, on the other.

Within the past 50 years, as the Chairman of the Committee has emphasized in his intro-

duction, revolutionary changes have taken place in the practice of medicine because of various important discoveries in the causation, treatment, and prevention of disease. Within that time bacteriology, serology, and x-rays have developed; hospitals have grown to enormous proportions; nursing has come to occupy a place not formerly thought necessary; specialization is now an important part of medical practice; medical education occupies a far longer time and is much more expensive than formerly; and apparatus for the diagnosis and treatment of disease now requires the investment of a large amount of capital.

Such changes in themselves would have increased the costs of medical care, but the problem has been rendered much more complex by the rapidly changing conditions in society and industry. The population of the United States has changed in a comparatively short time from one predominantly rural to one in which 50% of the people live in cities. This means that a much greater percentage of the people are now employed in industries than was formerly the case. Along with this urbanization and industrialization, there have developed radical changes in the standard of living. The luxuries of the late nineties are now necessities of life for great masses of the population. All of these changes, both in the practice of medicine and in society, have operated to cause an increase in the costs of taking care of people when they are sick. There is little doubt that the changes are desirable but it is obvious that they increase the costs of medical care.

It is plain, therefore, that many of the problems which are under discussion are the general problems of a transitional stage in social development and are not peculiar to medicine or medical care. Their solution must depend upon far-reaching social and economic adjustments. They are analogous to the problems which caused great social and political unrest in the last decade of the past century and which were not settled until there was a general increase in wages to compensate for improvements in the standards of living.

It does not seem probable to this minority group that these complex problems can be solved nor necessary social readjustments hastened by the widespread adoption of the recommendations of the majority of this committee for the group practice of medicine or group purchase of medical care.

Our understanding of the majority report is that it offers essentially the following type of practice in the future: The medical profession is to be formed into large or small groups, preferably large, and these groups are to furnish medical care under some type of contract with groups of laymen, the funds to be furnished by insurance, preferably of the voluntary type. Over against this we offer medical care furnished by the individual physician with the general practitioner in a central place; with careful trial of new methods based upon sound experience; and with adoption of insurance methods only when they can be kept under professional control and destructive competition eliminated; all of this through a well-organized, untramelled medical profession true to the great traditions and ethical standards of the past. Centuries of progress in the conquest of disease give us confidence that the individual and not the group should remain the unit in the practice of medicine.

Public Presentation of the Report of the Committee on the Costs of Medical Care at the Academy of Medicine of New York, November 29, 1932

THE MINORITY REPORTS

Explained by
Nathan B. Van Etten, M.D.,
New York City

I have the honor to comment briefly upon some divergent visions of a few members of our Committee upon the solution of the problems of "The delivery of adequate scientific medical service to all of the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life". All of the studies were pointed at this target

or at sources of reflected light which might illuminate it.

The work of the Committee carried on by an exceptionally able Director and staff, is monumental and we learned much about adequacy, costs, and distribution, and the details of many experiments supported by masses of statistics which were delivered so rapidly and so continuously that there was some inevitable indigestion when we suddenly changed into gentlemen of the jury who must weigh evidence and recommend cures for a faulty social operation.

All concurred in praise of the diligence, skill, and logical presentment of the findings and in most of the interpretations. All tried to harmonize themselves into unanimity with such success that upon only a few fundamentals or implications are there dissentient opinions. One believes that the report has missed the target; another that the recommendations have fallen short; and others believe that the mark has been overshot by excursions into Utopian idealism.

The objections of the minority composed of 8 physicians and a clergyman, are to the recommendations in "Organization of Medical Services", and "Group Payment for Medical Services". The minority report of 2 leaders in the national dental organization is in general accord with the first minority, but in agreement with the majority upon "Group Payment".

The minorities desire changes in medical education, urging—in addition to the present scheme which seems to qualify sufficiently for the care of 80% of the ills of mankind—emphasis upon the development of clinicians and added accent upon the importance of teaching disease prevention. They wish that mere prudential ethics may be strengthened by spiritual ethics and that only those possessing high character and high educational qualifications be admitted to the professions.

Premature specialization and over-specialization will be cured by the special societies acting within themselves, and the evolution of dentistry into whatever its destiny as a department of medicine will be determined by the concerted action of a well organized profession.

The minorities object to contract practice whenever it operates in restraint of opportunity for all competent and reputable physicians in the community, or results in unfair competition or furnishes inferior medical services. The same objections are made to pay clinics when operated for profit by laymen as "exploitation of the public and of the medical profession" through inferior quality of service with no lessening of the costs of medical care to the patient who must add operative charges to the normal or average fee prevailing in the community.

The minority claims overemphasis upon the virtue of group clinics and cites in opposition the large number of groups treating patients under workmen's compensation laws, in active competition one with another, "soliciting patients through paid agents". Many of these groups are under lay control—keeping down costs by employing physicians of low ability, commercializing medical practice, lowering ethical standards, demoralizing physicians into undignified advertising in factories, reminiscent of the old lavatory posters, leading physicians to compete for practice by buying cases for 1/3 or 1/2 of their fees and, in collusion with agents, prolonging treatments far beyond reasonable limits and padding their bills, as developed publicly by the Seabury investigation this year, and not denied.

The minority objects to the influence of this Committee being used in the promotion of new forms of political bureaucracy, feeling that the unsatisfactory operation of the forms of compulsory sickness insurance now carried on in 44 states under Workmen's Compensation Laws has degenerated into racketeering in our large cities and should be corrected by legislative action which should lead to real revision of these operations and carry them into the administrative hands of those who represent the higher medical honor and higher medical intelligence of the community.

Here the hospital or medical center may furnish the place and the skilled staff service, all of which should be amply paid for.

No argument demonstrates a *quality* of service, in countries where compulsory health insurance prevails, which is superior to the admittedly inadequate and badly distributed ser-

vice now operating in the United States. Quoting from Simons and Sinai:

"Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance."

The Minority Report states:

"It ought to be remembered that compulsory insurance will necessarily be subject to political control and that such control will inevitably destroy professional morale and ideals in medicine. Since a qualified and untrammelled medical profession is the only agency through which scientific medicine can be applied for the benefit of the people, it follows that any plan which destroys professional morale will bring disaster to the public."

Quoting again from Simons and Sinai:

"While the statement might be disputed by insurance societies, a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are entrusted to the medical professions."

This statement is both a challenge to the medical profession and a warning to those who, without proper consideration of that profession, are willing to recommend the adoption of various new plans for the care of the sick.

The minority feels that our Government has strained paternalism far beyond moral justification in the extension of veterans' hospitals and in the hospitalization of veterans with non-service disability and has spent the people's money with inexcusable recklessness. This sorry exhibition should make us all shy of Government invasion into control of any phase of medical practice except, of course, in the field of public health and in the institutional care of those unemployable wards of the state—the tuberculous, the insane, the feeble-minded, or the hopelessly crippled.

The minority objects to the large medical center as projected by the majority on the ground of exclusion of many physicians, of oppressive competition, of big business technic erecting machinery which eliminates personality and destroys personal relations by factory forms. Mere bigness is often a liability. The city of New York is so big that real community interest and civic pride are crushed and the citizen taxpayers are too dumb to protest against a self-perpetuating political machine which rules them.

The minority recognizes the practicability of centering medical service in small places where there are only 1 or 2 hospitals and where all of the physicians of the community are permitted to use all of the facilities of the hospitals in a true community spirit, the institution being supported by taxation or by gifts. My personal opinion is that if all hospitals were open to all reputable physicians (not merely the laboratory facilities, but beds as well) many of the problems of public service would be solved. I had always believed this to be administratively impossible until it was positively demonstrated to run smoothly in a very large hospital. Places where there are no hospitals and few physicians, dentists, or nurses, must be served in other ways with the entire health service of the county concentrated upon ways of distributing urban surpluses into neglected fields.

The minority favors continued study of group practice, coördination of the medical, dental, pharmaceutic, hospital, and nursing professions, the study of the application of the insurance principle to the accumulation of reserves, and to the assurance of solvency of institutions.

The "challenge of the future" in the majority report is a vigorous, stimulating statement that the work is not only not finished but only just begun, and that continuous widespread efforts must be carried on through all medical, educational, and all other agencies whose interest leads them earnestly to desire the prevention of disease and the general health of our people.

THE PRESENT AND FUTURE SIGNIFICANCE OF THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE—FROM PHYSICIAN'S POINT OF VIEW

Lewellys F. Barker, M.D.,
Emeritus Professor of Medicine, Johns Hopkins University Medical School,
Baltimore, Md.

As a physician, I feel that both the public and the medical profession should be very grateful to this Committee, first, for its careful analysis of the whole situation; and, second, for pointing out the paths that it regards as most promising for better things in the future.

No one is more proud than I am of what the medical profession has done in this country in the way of medical research, in the way of medical education, and in the development of the possibilities of medical practice, but no one knows better than the medical profession that there are still great inadequacies of medical care and great difficulties in the distribution of medical care and in the payment of the costs of medical care.

There is something wrong in the country where provision is not made for the 80% of the people whose incomes are insufficient to supply them with proper medical care during serious illness. Of course, the medical profession does the best it can and the public is doing the best it can, as it thinks, but there is something wrong in an organization that does not make definite provision for the care of serious illness among 80% of our people.

The medical men all agree that patients should have competent doctors, that patients should have access to good facilities, that the personal relations between doctors and patients should be maintained, and that the costs of medical care should be within the reach in some way or other of everyone who needs the care; in other words, the costs must be in some way distributed so that every patient who needs care can have it.

In this report all kinds of efforts that have been made have been carefully summarized. There was a large variety described, some of them excellent methods; some of them are very defective; some of the methods of medical care are actually pernicious, as we medical men know perhaps better than the public knows. The Committee has recommended progress by a process of evolution rather than by revolutionary change and, as a medical man, that appeals to me as a wise recommendation.

In the discussion of agencies and distribution of costs, the Committee has avoided, on the one hand, the *laissez faire* attitude of doing nothing and, on the other, any sudden and rash venture into dangerous areas. It has recommended experimentation, especially by local groups.

As a doctor, it seems to me that if the recommendations of the Committee could be widely adopted, many of our present problems would be definitely solved; that there could be adequate curative and preventive medicines applied for all income classes; that ways of distributing, coördinating, and financing the costs of these services would be determined; the medical profession would be properly safeguarded and more adequately remunerated than now; the danger of degradation and demoralization of the indigent would be lessened, and the bugbear of a huge and dangerous bureaucracy would lose its terrors.

This Committee includes physicians and surgeons, social workers, public health workers, administrators, government officials, and representatives of the public. As has been said by several of the speakers, it is inconceivable that there could have been unanimity of opinion in such a group, undesirable that there should be unanimity of opinion. How could there be at this stage of development? Conclusions cannot be equally acceptable to all because of such varied interests and such different viewpoints represented on the Committee. The 2 things that are most criticized are the recommendations regarding group service and group purchase, and those are the 2 main recommendations of the Committee.

As to group service, there is great fear on the part of many in the medical profession that the domain of the individual doctor might

be encroached upon, that doctors would come under lay control, and that the personal relations of doctors and patients would be interfered with. When it comes to group purchase, there you run up against one of the things that immediately excites the fear of state medicine on the one hand and of compulsory insurance on the other. This violent opposition, talk of Socialism, talk of Communism, as we have heard, result largely from the bad patterns of group purchase that were established at first in Europe when the attempts were made to distribute costs. It is no wonder that those bad patterns should be feared; they should be, and they should be avoided.

The Committee foresaw a good many of these objections and in the majority report it laid great stress, as does the principal minority report, on the complete separation in any insurance principle of the costs of medical care from the cash benefits that go for loss of wages due to illness. By that single recommendation the Committee removed one of the chief apples of discord. If those 2 things could be kept absolutely separate in any general provision by distributing cost, you would avoid a great deal of trouble, for the principle of insurance was introduced in the first place not to provide medical care at all but for the relief of poverty. Medical care was tacked on as secondary consideration and in most of the European patterns the 2 were kept together and there was a continual clash between the physicians on the one hand and the social workers on the other. There always will be clash between social workers and politicians on the one hand and doctors on the other if those 2 things go together, cash benefits and care of illness; but even if cash benefits are kept entirely separate from the medical care, there are enough problems connected with insurance. Dr. Van Etten has referred to some of them.

In European countries the mortality rate has not decreased under this insurance system. In the second place, the average number of illnesses has been increased. In the third place, the average duration of illness has increased under the insurance system; and, in the fourth place, some wholly new diseases, namely, the compensation neuroses, have come as a result, apparently, of these laws.

However, bad as it has been in Europe, bad as some of their patterns established have been, the average care of the sick is better than it was before insurance was introduced. The average income of the dctors concerned is larger than it was before; and, a third point, no country that has resorted to the principle of insurance has given it up. Those 3 things must be remembered.

.The doctors on your Committee are members of the American Medical Association and they feel a great responsibility both to the public and to the medical profession, but we must not forget that doctors in general have a very individualistic attitude. They fear any mass action, any mechanization of medicine, and they are right, quite right. They realize, and rightly, the great importance of the personal relationship of doctor and patient, and they are very likely to react with violent opposition to any innovation on account of their conservative, individualistic attitude. They are afraid of innovation, very much afraid of it.

I want to warn my colleagues in the profession against too negative an attitude. This world is not static. This world is changing all the time. The medical profession must change with the rest of the world and keep pace with it. The negative attitude of our English and German confrères was very disastrous to the medical profession. That negative attitude did not prevent the development of health insurance in England and Germany. It put the doctors in a very false light. It excited public hostility against men whom the public were led to believe were acting from a selfish attitude rather than from a public spirited attitude; and, worst of all, the medical men lost their influence and leadership and had very little to say about the patterns of insurance that were established.

Recently medical men have waked up to that fact in Europe and have seen that some kind of insurance was inevitable, and helped to form new patterns of health insurance, tried to protect both the public and the profession and tried to keep the medical control of the purely professional aspects of the work.

Shouldn't we in this country profit by those

mistakes that were made in Europe? In my opinion, forms of health insurance are bound to be tried out in this country. They should be tried out. We must watch them and try to direct them in the right way and discover what place, if any, health insurance has in the American program. Let the doctors lead in this and try to determine the policies and make them good, instead of bad, and in doing so the publications of this Committee will be very helpful to them, and if doctors take that attitude, instead of the other, negative attitude, we will keep the good will of the public, avoid hostility, and maintain the dignity and ideals of the profession.

I welcome the minority reports. I welcome the statement of Mr. Hamilton. It is well to have those things put down, to see what groups and persons are thinking. I welcome the criticism of group practice, of the community center, of voluntary insurance. I see the danger of new evils and they have vividly portrayed them in their reports. Their emphasis on the county society method is well worth listening to. What the Milwaukee County Society has done might be imitated in other places. I should like to see that method tried elsewhere, but these minority reports and single statements ought to be very helpful. They ought to make everybody act more cautiously and more warily. To be forewarned about possible evils and dangers is to be forearmed against them.

Aside, wholly, from these differences of opinion, there are a host of opportunities for action. These opportunities ought to be recognized promptly and acted upon all over this country. There should be community organizations to study and to take the lead in the work, possibly some state organizations; no harm in a general national organization that will help and advise.

This Committee on the Costs of Medical Care goes out of existence this year. That must not be forgotten. What hard work they have done! What noble contributions they have made! The fact-finding alone is worth the cost of the whole Committee. The advice they have given has been very carefully considered. Surely it is up to the leaders of thought and action in this country to pay serious attention to the report of the Committee and to do what they can to bring about reforms.

I think we owe a great debt to the Director, to the Administrative Staff, to the Research Staff, and the Foundations whose financial assistance made the study possible, and I believe that the publication of this report today marks the beginning of a new epoch in American history.

PRINCIPLES AND POLICIES OF ORGANIZED MEDICINE

William Allen Pusey, M.D.,
Chicago, Ill.

(Presented at the Annual Conference of State Society Secretaries and Editors in Chicago, November 18, 1932)

Principles

(1) Medicine is the trustee of society in the care of the sick and injured; its policies must always be governed by this fundamental fact.

(2) The good of society must be the sole aim of its public policies and the good of the patient the first consideration in the relations between physicians and patients.

(3) Medicine's first responsibility must be to see that its services are available to all men.

(4) The public interest demands the most competent medical profession possible. Medicine must be an attractive profession to compete successfully with other professions for the ablest young men.

(5) In the sense that every calling from which a living must be gained is a business, medicine is a business; it must accept the competitive conditions of practical life but, as a profession of high ideals, it must seek to prevent selfish commercialism.

(6) Experience has shown that the vast majority of disease conditions afflicting man can be most satisfactorily and economically diagnosed and treated by a competent individual general practitioner.

RESPONSIBILITIES

(7) The services of medicine include (a) the practice of medicine; (b) the promotion of preventive medicine and the public health; (c) the fostering of research and the increase of knowledge.

(8) Medicine's chief concern must be for the individual physician; the service rendered by individual physicians in the aggregate constitutes the great bulk of medical service. The quality of service which is given depends on the competency of the individual physicians who give it.

RIGHTS

(9) The medical profession asks for its practitioners: freedom of opportunity to develop to the limit of their individual capacities.

(10) It asks a career of independence under conditions of free and dignified competition.

(11) It asks remuneration sufficient for reasonable comfort for the individual and for his family.

(12) In its ideals of independence, medicine has a right to control its own affairs. Its history of capacity and altruism justifies this claim.

TRISTATE MEDICAL CONFERENCE

Atlantic City, N. J., December 10, 1932

The twenty-first Tristate Medical Conference convened at Hotel Chelsea, Atlantic City, and was called to order at 10.50 a. m. on December 10, 1932, by Dr. A. Haines Lippincott, President of the Medical Society of New Jersey, and with the following members and guests in attendance:

New York: William D. Johnson, Batavia; George M. Fisher, Utica; John A. Hartwell, New York City; Joseph S. Lawrence, Albany.

Pennsylvania: Donald Guthrie, Sayre; William T. Sharpless, West Chester; Arthur C. Morgan, Philadelphia; Edgar S. Buyers, Norristown; Frank C. Hammond, Philadelphia; Walter F. Donaldson, Pittsburgh.

New Jersey: A. Haines Lippincott, Camden; John F. Hagerty, Newark; Ephraim R. Mulford, Burlington; Walt P. Conaway, Atlantic City; J. B. Morrison, Newark; Henry O. Reik, Atlantic City.

Guests: T. C. Routley, M.D., General Secretary of the Canadian Medical Association; R. G. Leland, M.D., Chairman, Bureau of Economics, American Medical Association.

Dr. Lippincott: As President of the Medical Society of New Jersey, it gives me pleasure to welcome you to our State, and to express the hope that you will enjoy your visit as well as the program so ably prepared by our Secretary. This program promises to bring valuable information to the medical profession at a most critical time, perhaps *the most critical* in the history of medicine in these United States. With your permission, and without any further delay on my part, I will open this session, and ask Dr. Reik to explain the order of business.

Dr. Reik: In arranging this program it was intended to have presented and explained the question of *National Health Insurance,* the so-called *State Medicine,* as it has developed in England since 1911—of course with a number of modifications or amendments since the law was originally enacted—and also as it has come into some of the provinces of Canada. I have invited a gentleman to address you today who knows all about this matter, and who can tell you authoritatively how it operates. Dr. Routley has had an intimate relationship with organized medicine in the British Empire and will speak to you about conditions in England and Canada, particularly. Dr. Hartwell will present a résumé of the work of the Committee which for 5 years has been studying the costs of medical care.

I endeavored to get Secretary Wilbur to attend this meeting. Having known him for a good many years, I presumed upon that acquaintanceship to invite him, but I have only a letter from him expressing sincere regrets that he could not be with us today.

Dr. Van Etten, who is thoroughly familiar with the work of the Committee, likewise had a previous engagement, but I am happy to say that Dr. John A. Hartwell accepted our invitation and will explain to us the work of that

Committee; and then Dr. A. C. Morgan, as a signer of the minority report, will explain that document, and Dr. Leland will open the general discussion.

Dr. Morgan: May I ask if it is permissible for reporters to remain in the room?

Dr. Reik: It has been allowed before, and the reporter who is here has promised me that he will not publish anything without our endorsement.

Chairman: All of our members will want to hear our guest from Canada, and because some could not get here before 11.30, we will, if satisfactory to Dr. Routley, change the order of procedure and call upon Dr. Reik to present his paper.

A CHILD AMONG THEM—TAKING NOTES

Henry O. Reik, M.D.,
Atlantic City, N. J.

The Secretary of this Conference begs leave to explain that the projecting of himself into this otherwise excellent program had a double purpose: (1) that of aiding the first of our guest speakers—Dr. Routley—in the event that any aid became necessary, or seemed appropriate, to bring out all of the numerous elements concerning or related to the problem of "national health insurance"; and (2) that of presenting some recently acquired information which tends to confirm, or for other reasons should be added to, that obtained on a previous visit to England and published in the Journal of the Medical Society of New Jersey, of March 1931 (pages 246-252, inclusive).

If further justification be required, he could say today that recent happenings have not only afforded an opportunity for speaking but make it appear essential that each of us should now make known to the others, and in so far as possible to all members of our profession, whatever knowledge or information bearing upon this problem may have come into his possession.

Next, you will permit us to say that we made no inquiry as to Dr. Routley's views upon the questions at issue, and have at present no knowledge of his attitude toward so-called *state medicine;* i. e., whether he is in favor of or opposed to national health insurance. When extending him the invitation to address this Conference, we made but one request—that he should talk about *national health insurance* in Great Britain, with special reference to England and Canada, and that he should tell us *the truth.* Having brought from the Johns Hopkins University, and personally adopted, the motto—*veritas vos liberabit*—the point of our search in this matter has constantly been—ascertainment of the truth.

By chance, both Dr. Routley and your Secretary were Delegates to the Centenary of the British Medical Association in July of this year. The Secretary was treated most courteously, enjoyed every conceivable privilege, and felt that he had gotten into very "close touch with" that Association's officers. He observed, however, that the Secretary of the Canadian Medical Association was received with illimitable cordiality and treated as the peer of Delegates from all parts of the British Empire; a state of affairs not difficult to understand after you have become acquainted with Dr. Routley. Knowing, therefore, that if any one had gotten closer to the "powers behind the throne", that person was Routley, our quest for enlightenment terminated in the call for him to "come over into Macedonia and help us out".

The title of this paper originally was from one of Burns' poems, in the Scottish dialect—"there's a chiel amang ye takin' notes"—but fearing some of our readers, when it is published, would not understand, we decided it would be better presented in translated form. Its use here has reference to our presence at the Centennial Celebration of the British Medical Association, at London, in July 1932. Before presenting to you some of the notes made at that time, we will review for your benefit observations made on a previous visit.

It was our privilege in the Summer of 1930 to travel through Ireland, Wales, England and France, and we took advantage of that oppor-

tunity to gather as much information as a tourist may, flitting hurriedly from place to place, concerning the working and the present status of national health insurance or its equivalent in some type of group practice. We were instigated to that action by the desire to know the truth about such practice, particularly as to England, and our desire had its origin in a distrust of certain statements frequently published in this country—to the effect that the insurance practice in England had proved disastrous to both the people and the profession. For example, one of our best State Medical Society Journals published editorially the following statement: "The Company (referring to the intermediary organization handling such insurance) being the State, the physician supplied is the employee of the State and is under the control of that organization, body and soul. The patient has no choice whatsoever in the matter of selecting his physician. The result has been * * * dissatisfaction on the part of both physician and patient." Note, if you please, that the statement quoted contains 3 specific charges against the system used in England: (1) that the insurance physician necessarily becomes an automaton, under the control of an outside influence; (2) that the patient has no voice in the selection of his physician; and (3) that the parties most concerned—patient and physician—are affected deleteriously.

We could readily cite a dozen similar statements derogatory of the English system, some even more emphatic in general denunciation and in specific statements regarding the character of service rendered and concerning the alleged deterioration of physicians engaged in the insurance work, but repetition is scarcely necessary, in view of the fact that most of you have heard or read such statements during the past few days in discussions of the Cost Committee's report.

In the condemnatory statements most frequently used it is alleged that "the patient has no say in the choice of his physician". That statement is false; the charge has been denied many times; but it, and a few other equally false pronouncements, continue to be repeated and to block the road to honest consideration of the general subject. For instance, returning to the example quoted above, on the day we chanced to read that time in a State Society Journal we had on the desk several other Journals containing items of the same general tone and, as we had reason to doubt their authenticity, we wrote to the Editors of those Journals for information: Upon what did you base that statement—personal contact with or knowledge of the practice in England? —reports from trusted friends practicing over there?—or, what dependable source? Answers received were uniform, and about as follows: Each writer opened with an expression of surprise at our challenging the statements; followed with a confession that he did not know their origin, or that he remembered, vaguely, having seen them in some other Journal; and concluded with the explanation that he had read or heard such statements so often that he had supposed they were from a trustworthy source. Well, they were not; we were reasonably sure of that at the time, but we took the trouble to study the whole matter as if it were a new project, and we found those charges thoroughly disproved. Let us, then, temporarily at least, dispose of the charge pertaining to choice of physician by saying that the very first feature of the National Health Insurance Act in Great Britain is a guaranty of the insured person's right to choose his own physician. With that question out of the way we can proceed to further study of the subject in an orderly manner.

In order that our statements shall be as accurate as may be, we shall quote only from official documents: (1) The Statutes, Regulations and Orders relating to National Health Insurance, published for the Ministry of Health, by His Majesty's Stationery Office, Adastral House, Kingsway, London, 1929. (2) Medical Insurance Practice, prepared by R. W. Harris and Leonard S. Sack, and issued by the British Medical Association for the guidance of health insurance practitioners. We need scarcely explain that the first mentioned book comprises the original law and its amendments, in 133 paragraphs, each of which bears marginal annotations of explanatory nature, and such official regulations as have been found necessary in application of

the law. The second book is of greater value for our present purpose, because it constitutes an interpretation of the law in the light of all that has happened since its inception 19 years ago.

In September 1922, Mr. Harris, an Assistant Secretary in the Ministry of Health, and Mr. Sack, Barrister-at-Law, both of whom had been associated with the Government's efforts to apply the Insurance Act and make it workable, joined in writing this "book of reference" so that the insurance physician could have at hand authentic answers to all questions arising in his work. A second edition, made necessary by amendments incorporated into the law, was published by the authors in 1924. Publication of the third edition, in January 1929, was taken over by the British Medical Association, for the benefit of its many interested members, and bears the stamp of that organization's approval. The preface to this most recent edition was written by the Chairman of the Insurance Acts Committee of the British Medical Association, Dr. H. G. Dain, and the first paragraph reads as follows:

"It must to many have seemed amazing that so everyday a matter as the doctoring of a person could have produced or required such a mass of regulations and terms of service, but the present conditions are the outcome of experience and necessity. Consideration will show that the need for so complicated a system is brought about in the main when the service rendered by the doctor to the patient is provided and paid for by a third party who is never present when the service is rendered, and by the insistence of the medical profession on the right of every registered medical practitioner to go on the panel, if he wish, and on the right of free choice by both doctor and patient. For these fundamental principles we pay in complicated regulation."

Half submerged in that paragraph is a phrase worthy of special attention by those of us who have been fearing the advent of *state medicine* in this country. Recall the facts that the Association strenuously fought against acceptance of this law and a large proportion of its members refused at first to enroll for service, and then note the present *"insistence of the medical profession on the right of every registered practitioner to go on the panel,* if he wish"; and ponder on the changed attitude.

At present the law is limited in application to about 15,000,000 citizens—embracing only persons, of either sex, above 16 years of age employed in manual labor or in other labor for which the remuneration is not more than £250 ($1250) a year; and a small group of persons who because of previous alliance with other health insurance schemes are permitted to hold over as "voluntary contributors" to this plan.

The insurance benefit fund is provided through contributions by the insured employees, their employers and the state. In the original scheme the fund was to come—"as to seven-ninths from contributions of the employed person and the employer and two-ninths from the Exchequer", but numerous changes have been made as necessity required an increase of the total fund, and consequent increase in the per capita assessment, until at present "a sum of 13 shillings ($3.25) per annum is ear-marked by statute for medical benefit (average per person), * * * and the contribution of the Exchequer (toward this 13 shillings) is one-seventh in the case of men and one-fifth in the case of women". If we study the figures for a fiscal year, which take into consideration interest earnings, etc., it will be seen that each 13 shillings' item is secured by assessing the employer for one-third, and the insured laborer a trifle less than one-third; or, in simpler language, the employee secures health insurance at a cost of approximately 4 shillings ($1).

Enforcement of the Act is under direction of the Minister of Health, but practically all normal negotiations with the insured are carried on through "approved societies"—insurance companies, as it were—with whom the Government has contracted to look after such details.

The benefits provided for insured persons comprise:

(1) Medical treatment and attendance (called "medical benefit"), including proper and sufficient medicines and chemicals as may be prescribed, and surgical dressings and ap-

pliances; but does not include obstetric attendance or treatment.

(2) Periodic payments while incapable of work because of some disease or bodily or mental disablement, for a period not exceeding 26 weeks (called "sickness benefit").

(3) In the event of disease or disablement lasting longer than 26 weeks, payment of a "disablement benefit" during continuance of incapacity for work.

As will readily be seen, the above provisions make it necessary that the attending physician shall furnish:

(1) Medical attendance and treatment such as is expected of a general practitioner.

(2) The prescribing of proper and sufficient remedies.

(3) Prescribing or supplying suitable surgical dressings and appliances.

(4) Keeping of accurate records and furnishing if and as required certificates of disablement or incapacity.

We may be forgiven for saying at this point that the last mentioned requirement has been the cause of more trouble than all the others combined. Physicians, everywhere, just loathe what in the army they called *paper work*. No group of people understands better the necessity for and the value of accuracy in small things; and no group has a greater dislike for the task of making and preserving accurate records.

Who may practice? In theory, at least, this service might have been rendered by full-time salaried medical officers, or it could have been entrusted to specially selected part-time general practitioners, but, in fact, "Parliament decided to throw this service open to the whole medical profession and accepted the basic principle that *every qualified medical practitioner is entitled to treat insured persons",* provided that he has not been disqualified by misconduct.

Any qualified medical practitioner (in fact, that means any member of the British Medical Association in good standing) can share in the insurance practice by merely expressing the wish and signing the roll of The Panel, more formally called "The Medical List".

Here let us again pause for comment. In confiding this work to properly qualified, licensed, registered physicians, and in otherwise placing all professional matters under control of the regular profession, Parliament and the Health Ministry knocked the props almost completely from under the *cults*. Furthermore, you may have noted that the panel doctor is only required to serve as a general practitioner; he is not expected or required to act as a specialist in any branch of medicine or surgery. In practice, that provision has helped materially to solve the problems involved in fixing a dividing line between general and special practitioners. The insurance Act provides for consultations and for referring patients to surgeons or other specialists, but as it does not provide payment of panel doctors for work out of their proper sphere, they are not tempted to perform any operations except those required by emergency—and small emergency operations are recognized and compensated for when properly attested.

Selection of physician. "Every insured person is entitled to medical treatment, within the range of service provided, whenever and wherever required (in Great Britain). The insurance doctors in any area have a collective responsibility for the medical treatment of every insured person in the area who applies for it."

As previously indicated, the worker registers with and pays dues to an insurance company—"approved society"—and receives a card of identity, which card he takes *to the physician of his own choice,* and, if acceptable to the latter, registers upon that physician's panel. The chosen physician is, however, entitled to refuse to accept the applicant, and in that event the Insurance Committee will aid the insured person in selection of or assignment to another physician. The only *obligatory* acceptance of a patient deals with the rendition of service in an emergency. There are elaborate provisions covering every possible exigency that may arise to disturb the relations of physicians to patients; and, in dealing with such problems, as with all other problems associated with application of this law, the medical profession is adequately represented on the committee of adjustment.

Limited Size of Lists. "As a limit to the number of insured persons, well and ill, for whose treatment an insurance doctor can undertake responsibility, a maximum of 2500 insured persons is fixed and no single-handed insurance doctor may ordinarily have more than this number on his list. ***Where 2 or more doctors carry on a practice in partnership, any one of the partners may have up to 3000 names on his list, but the *individual average* of the lists of all the partners must not exceed 2500."

Keep in mind that the above mentioned figures *do not mean 2500 patients*; they only mean 2500 persons any of whom may become patients at some time. Save during epidemics, there is rarely more than 1% of such listed persons ill at any given time.

Payment for Services. Various methods of payment were considered—such as payment by salary, payment for number of cases treated, payment by a fee system according to character of services rendered—but it was finally decided to pay on a per capita basis of the insured population, well and ill. So, at the beginning of each year the department sets aside a specific fund based upon an estimate by the Government Actuary of the number of insured persons multiplied by the agreed capitation fee. The gross fund available for medical service is then apportioned among the counties or boroughs, according to respective proportions of insured persons, and allotted to physicians in accordance with the relative number of persons on the list of each. There is also an apportionment to pharmacists, to cover prescriptions filled and appliances furnished, and an additional fund to cover medicines and supplies furnished by physicians in areas where pharmacies are not available. The distance a physician may have to travel to care for a patient is also taken into consideration and he receives mileage for all calls beyond a certain distance from his office.

It might be expected that incomes from this source would vary considerably, and we assume that they do, but we were told that the average income from this insurance work in manufacturing districts, where laborers are naturally congregated in largest numbers, is approximately £1000 (nearly $5000) and that incomes of £1500 are not uncommon. We cannot vouch for the accuracy of those figures; they were proffered, in fact, as estimates, or guesses, but by individuals who were or had been in positions that enabled them to make a "reasonable" guess. We can, however, offer some figures from a reliable source and applicable to the entire country.

The Thirteenth Annual Report of the Ministry of Health (p. 233-234), covering the year 1931, shows that there were 14,840 physicians engaged in this insurance practice and that they received the sum of $31,429,620 in respect of their duties of attending and treating insured persons; the insurance roll for that year numbering approximately 15,000,000 insured persons entitled to medical benefit.

Those figures would indicate an average of $2118 for each panel physician in the entire country; not a bad average income from one single line of practice. In addition, the treasury reports, for the same period of time:

"About $1,000,000 was paid to country doctors on account of mileage, another $1,000,000 was paid to doctors for medicines and appliances supplied by them as part of emergency treatment or dispensed in country districts, and $50,000 was set aside to enable country doctors to attend courses of post-graduate study and to provide them with other desirable facilities (maintenance of telephones, motor cars, branch surgeries, or reasonable vacations)."

Some details of service. When a physician signifies his willingness to register on the "Medical List", for health insurance service, he receives, along with notice that he has been enrolled, a copy of the List of Insurance Pharmacies, a supply of prescription blanks, record cards, certificates of illness or incapacity, and other regular forms.

The general standard of treatment required is that which one would observe in his private practice as a general practitioner.

Every formal complaint, or any other formal question arising between a physician and an insured person, is required to be investigated by a body composed of an equal number of medical men and of insured persons' repre-

sentatives, with an independent chairman—the Medical Service Sub-committee of the Insurance Committee. There is a subsequent right of appeal to the Minister.

In complaint cases an insured person's Approved Society may be permitted to assist him in the presentation of his case; the Society itself may be the complainant in certification cases; but, apart from this, and excepting certain details of certification procedure, you will find that your only relations with Approved Societies are those of an informal nature in which the officials communicate with you on behalf of members. Such informal communications are all to the good—particularly where an illiterate member is concerned—if on both sides it is recognized that the communications have no official footing.

For purpose of local administration of Medical Benefit, each country is divided into areas, one for every county (in Scotland, areas are amalgamated in 2 or 3 instances)and one for every county borough, and in each area there is set up an Insurance Committee responsible to the Minister, for the administration of medical benefit within its area.

There are also set up in each area: a Local Medical Committee, representative of doctors generally who are resident in the area; and a Panel Committee, representative of the insurance doctors who are under agreement with the Insurance Committee.

In his relation to insurance doctors, the Minister is placed in a somewhat unusual position. While he is responsible for the spending of public money on the administration of medical benefit, he has not the customary powers of selecting the persons by whom the work is to be carried out—every qualified doctor having, as already explained, the right to treat insured persons.

The Minister is, however, entrusted with the responsibility for the issue from time to time of the Regulations, etc., which define the insurance practitioner's Term of Service. He must also, in view of his responsibility to Parliament, have some check on the way in which these doctors carry out their obligations. But the Regulations afford evidence that the Minister in the exercise of his powers under the Acts is relying more and more on coöperation of the medical profession, especially where professional questions or professional conduct are at issue.

In this connection his main concern must be that the committee coming to discuss matters with him must (1) have the necessary mandate, and (2) if undertakings are given, be in a position to secure that they are carried out. The body which is recognized by the Minister as the representative body is the Insurance Acts Committee of the British Medical Association, and all questions affecting remuneration or other Terms of Service, for insurance doctors, have always been made the subject of consultation with this representative body, and Ministerial undertakings have been given that this course will continue to be pursued.

Panel Committees are required by the National Health Insurance Act to be set up, and Insurance Committees are directed to ascertain through these bodies the opinions and wishes of insurance doctors, wherever these are required to be ascertained by the Act or the Regulations.

The Panel Committee can require that the Medical Service Sub-committee shall investigate any question relating to the administration of Medical Benefit or to the discharge by an insurance doctor of his duties. It has also the duty of adjudicating in cases where there is *prima facie* evidence of extravagant prescribing by a doctor.

The scheme of National Health Insurance does not, it will be seen, provide for "specialist services", i. e., services which are ordinarily beyond the skill or experience of general practitioners. Questions of importance, and often of not little difficulty, may, therefore, arise as to whether a particular operation or service which an insured person admittedly required falls within the definition of general practitioner treatment quoted above.

The Regulations provide that, where a question of this nature arises, it is to be referred to the Local Medical Committee, and if that Committee and the Insurance Committee—on considering the Local Medical Committee's report—fail to agree, it is to be sub-

mitted for decision to 3 Referees, appointed by the Minister, 2 of whom must be doctors, the third being a barrister or solicitor in actual practice.

Emergency Treatment. In case of an emergency the doctor is required to render whatever services are in the best interests of the patient, having regard to the circumstances. In other words, the test must be solely what treatment, within his capacity, the patient urgently requires. Thus, cases of great urgency may arise, more frequently in country districts, "where the risk to the patient, through your undertaking an operation which, in other circumstances, would better be left to a specialist, is less than the risk entailed by delay".

The general capitation fee, paid for the treatment of insured persons in town and country alike, covers professional services and practice expenses. It therefore includes payment for a certain amount of traveling. Doctors who practice among insured persons in rural and semi-rural areas receive an extra payment in connection with work done (1) beyond 2 miles from the doctor's residence or main surgery, and (2) in districts which present exceptional traveling difficulties. This extra payment is one which takes account both of the time occupied in traveling and the cost of traveling.

Insurance premiums are paid to the doctors in the Insurance Service for every insured person in the country, well and ill, and the remuneration of every practitioner is provided for in the Distribution Scheme for the area in which he practices. "Accordingly, the Regulations provide that you must not demand or accept any other payment for giving treatment, within the range of service laid down by the Terms of Service, to any insured person who is on your list, or who represents to you that he is an insured person, except by way of deposit, in cases of doubt."

Criticism of existing plan. As already stated, in the beginning, this law was strongly opposed by the medical profession. Nearly all physicians looked upon it as an unwarranted interference with their legally established professional and business rights, and many denounced the general plan as a socialistic experiment fore-doomed to failure. Prediction was made that if it should happen to succeed to a recognizable degree it would, nevertheless, prove detrimental to the public and degrading to participating physicians; these dire prophecies being based upon the fear, or expectation, that the service rendered could not or would not be up to standard, and that through such a lowering of professional service physicians would themselves deteriorate. There was even talk of a "strike"—of medical men refusing to have anything to do with this new form of "contract practice".

Well, like many other horrors, these were disposed of with less difficullty than had been anticipated. Sober second thought must have convinced many objectors that (1) the oft-repeated experiment of holding back the tides with a broom had never yet succeeded, and (2) that their fears of professional deterioration—in practice and in reflex effect—were not flattering to themselves. At any rate, 14,000 physicians in England and 937 in Wales are now "on the panel", and our inquiry as to how the organized profession now feels about it brought the response that: "If submitted to the British Medical Association for a vote, the question—of supporting the present health insurance law or having it abolished—would bring out a tremendous majority in favor of existing conditions, *because it has benefited both public and the profession*".

In recent years criticism has taken the form mainly of charges that some bad results have accrued, or may yet develop. For instance: excessive prescribing of extravagantly expensive drugs; malingering, encouraged by doctors who may be too easily induced to sign certificates of disability or incapacity; repetition of the fear that the profession will ultimately suffer a slump in scientific output as an indirect result of slothfulness that some consider a natural development among those engaged in contract practice or institutional work.

We sought factual information upon those points. There have been many instances of malingering and some cases of certificate fal-

sification and of prescribing. There is some evidence that malingering exists among the insured (especially among married women under 45 years of age) to a greater extent than among people of the same class in other comparable countries or in Great Britain prior to enactment of the insurance law. Advocates of the insurance scheme are, however, quick to point out that all the above mentioned complaints and objections are *criticisms of human nature* rather than of the law; that the bad results, where proved, are due to moral defects and obliquities on the part of some patients or some physicians, and do not constitute any more serious criticism of this law than do evasions of other laws justify their condemnation.

Inquiry through medical channels elicits, as might be anticipated, the prompt denial of professional abuses on any large scale; admitting that a few panel physicians have been guilty of aiding and abetting malingerers, and of abusing prescription privileges, it is claimed that the total number of such transgressors constitutes but a small percentage of the whole number of panel doctors. Honest panel physicians also point out the fact that *moral delinquency is not an unknown occurrence among physicians engaged solely in private practice.* In so far as the medical profession is concerned, we may safely conclude that the percentage of wicked physicians is not higher among those engaged in state medicine than among those occupied with private practice alone; that the number and the percentage of wicked workers in either group is very small; and that such abuses of the law as have grown out of too great complacency on the part of physicians—whether to favor patients or pharmacists—are reflections upon human character rather than justifiable criticisms of the law.

There is apparently mighty little complaint in England as to the quality of service rendered by panel doctors; and that is not only what we would expect but speaks well for the honor of our profession. The people appear to be satisfied; the Government seems to be satisfied; in fact, the opinion seems to be general that—*the class of people insured is now better cared for medically than ever before, and that physicians are now paid for services which formerly they were compelled to render mostly on a charity basis.*

The intimation that physicians, as a group, will render a lower grade of service to panel than to private patients, and the fear that any considerable number of physicians will lose interest in medical science just because they happen to be engaged in what somebody has called *wholesale, as compared to retail, practice,* are propositions that seem to us unworthy of discussion; indeed, they can hardly be discussed without first accepting fundamentally the implication that the medical profession is composed largely, if not in the main, of greedy, grasping, reward-seeking individuals who base the quality of their service upon the amount of pay to be derived and who have no other interest than a selfish financial one in the progressive development of themselves and their science—*and those are allegations that all history denies.*

Control of excessive or extravagant prescribing, and of improper certification of illness or incapacity to work, is to a certain extent in the hands of our profession's representatives upon the various committees executing the law and in the British Medical Association.

The extent of malingering is in a manner indicated in the Health Ministry's Annual Report for 1929, and the figures used in the next paragraph are repeated from our previous report because those for 1931 are not at this writing available to us.

"The number of references to regional medical officers for advice as to incapacity for work in 1929 was 410,903 (408,934 from approved societies, 1079 from insurance doctors, and 890 from insurance committees). Of these references 133,707 (or 33%) related to men and 277,196 (or 67%) to women. The number of persons actually examined on incapacity references was 211,634. The number who declared themselves *off the funds* before the date fixed for examination was 109,661, and 89,750 failed to attend for other reasons. Of the persons examined 143,898 were reported as incapable and 67,736 as not incapable of work."

The above figures show that practically one-half (49%) of all malingerers who carried their claims to the point of demanding a certificate of incapacity were eliminated by the simple expedient of requiring submission of the question to a referee. Of the number submitting to reference examination, approximately two-thirds were found to be actually incapacitated and one-third to be malingerers; which, in turn, indicates that only about 35% of the original claimants were sustained, and 65% were weeded out.

Before leaving this portion of our talk—this summary of such facts as we were able to glean from a cursory study of the law operating in Great Britain—*let us say, emphatically, that we have not attempted nor meant to advocate, or argue in favor of, establishment of so-called state medicine here.* We have tried to ascertain the facts concerning national health insurance in Great Britain and to present those facts in logical sequence and in an unprejudiced manner; at the same time presenting such answers as were vouchsafed us with reference to criticisms. We confess to having been aggravated many times by statements published in various American medical journals—statements which we felt certain were misrepresentations, or unjust charges, or unfair deductions and inferences—and it is possible that we have exhibited the reaction-effect of such an influence. It is difficult for any of us to present any debatable question with absolutely perfect impartiality. Herein, *we have tried to present both the facts and the explanations without bias,* even when emphasis seemed necessary, but we have been conscious, too, of a feeling that the facts, in their strongest form, had best be faced. If there is either a threat or a natural prospect of state medicine coming soon for consideration here in New Jersey, or in any of these United States, we cannot afford to blink the facts; and, in our humble opinion, the wisest preparation for dealing with the problem consists in first learning all we can about the experiences of other countries.

Stand of the British Medical Association as Regards the Future

Whatever opposition the British Health Insurance Act encountered in the beginning, and whatever criticism may be directed at it now, it is a noteworthy fact that the *British Medical Association has recently submitted to the Government a proposal to extend that law*—with slight modifications—to embrace the entire populace and to cover medical practice in all its varied aspects. The proposed plan includes preventive as well as curative medical service; treatment by specialists as well as by general practitioners; hospitalization and convalescent provisions as necessary; auxiliary service in the line of radiography, electrotherapy, physiotherapy, hydrotherapy and massage; mental disease institutions and maternity homes; infant welfare and school inspection; coördination with public health departments; and all to be available to the indigent as well as to those who can pay in part or in full for health insurance. It is a thoroughly comprehensive scheme. And this is the result of 19 years of observation, study and experience on the part of the physicians of Great Britain. If adopted, the plan would not entirely destroy private practice; while all physicians would be eligible to state practice, none would be forced to take part, and persons desiring to employ private, non-participating, practitioners—general or special—would be at liberty to follow their own bent.

The single modification of the existing law asked for, in so far as we have discovered, is that provision shall be made for direct contact between patient and physician instead of negotiations through any third party—meaning the "approved society".

"That the interposition of any third party between the doctor and the patient, so far as actual medical attendance is concerned, shall be as limited as possible. In the first place, the relations between doctor and patient are so intimate that both doctor and patient rightly resent any outside interference. Such interference is bad for the doctor and worse for the patient. It is bad for the doctor because his whole training and the traditions of his

profession tend to foster the idea of personal responsibility, and this can be undermined only at the risk of rendering the doctor less efficient. It is worse for the patient, because, *ex hypothesi,* he or she is a sick person whose cure depends very largely on complete confidence in the doctor, and this confidence is built up to a great extent on psychologic factors which are disturbed by the intrusion of outside agencies. The Association pleads on behalf of the poorer section of the community that they should have the same consideration in this matter as is demanded as a matter of course by the more wealthy sections of the community. There is no more reason why any third party should come *between the patient and his medical adviser than between the individual and his spiritual adviser.*

The experience gained from the National Health Insurance system has shown that the interests of the public are best served in any organized medical service by putting as much responsibility as possible on the doctors giving the service—responsibility, that is, for the quality of the service and for its smooth working. There are no severer critics of delinquent doctors than a body of their own colleagues invested with the control of purely professional affairs. And there is no surer and easier way of securing an efficient service than to enlist the active interest of those whose reputation as a profession is involved in the way in which they exercise collective responsibility entrusted to them."

In sponsoring the proposition, the Association further says:

"During the past 20 years the attention of the public has been directed more than ever before to the subject of 'The Health of the People'. Many factors have led to this increase of attention. The systematic medical inspection and treatment of school children; the National Health Insurance system and the varied experience gained from it, including the striking evidence as to the loss of millions of weeks of work in a year owing to ill health among the insured population; the establishment and the activities of the Ministry of Health; the devastating influenza epidemics; the experience gained from the operations of the maternity and child welfare schemes of the local authorities; public inquiries into different aspects of the question, such as the reports of the Consultative Medical Councils in 1920, the Report of the Royal Commission on National Health Insurance in 1926, and, more recently, the inquiries into the subject of maternal mortality; the increasing interest in the subject taken by the press—all these have combined to make the problem of how best to promote the health of the people one of the most interesting and pressing public questions of the day.

The British Medical Association, as a body representing the great majority of doctors in this country and in the British Empire, has not been inactive all this time. It has indeed been busily engaged in studying in detail various aspects of the question, with the object, first, of eliciting the views of the main body of the profession and then of focussing those views into practical schemes. Many of these sectional schemes have been placed before the Government; some, such as the recent plan for dealing with maternal mortality, have been given wide publicity. The Association now feels itself to be in a position to piece these plans together and to submit to the public a coherent and inclusive scheme of medical service based on a few simple basic principles. This scheme would, it is believed, provide the community with a service available for every class of the population, comprehensive enough to cover the whole field of preventive and curative medicine, and sufficiently elastic to permit of further developments as these may be found necessary. As the Association said in a pamphlet published in 1918, stating its views as to the way the new Ministry of Health should work: 'The system of medical provision which the Ministry of Health should seek to establish is one which would give to all who need it every kind of treatment necessary for the cure or alleviation of disease, and would utilize for this purpose every class of medical practitioner.'

A comparison of the National Health Insurance system of the country with those of other countries shows that the quality of the

service given here is in many ways superior to that of many other countries, and certainly there is a more contented service, mainly because *the management and control of the purely professional side of the work and the disciplining of the doctors connected with it have been increasingly entrusted to the profession itself."*

We have reviewed this matter today rather fully for the reason that, despite the fact of its having been published more than a year ago, it is still *à propos* in answer to questions which still persist, and it is opportune for application to the problems just posed by the Committee on the Costs of Medical Care.

Now, what did we acquire from the visit to London? We could answer briefly by saying—confirmation of our views as previously recorded—but, that would neither fully nor satisfactorily suffice. We learned a great deal more, and there are several matters we would like to submit for consideration, now that the situation in this country has become more acute and—as it appears to us—a definite course of future action needs to be determined, and that determination is needed promptly as well as definitely.

Before leaving London we spent a half day with Dr. Cox, Secretary of the British Medical Association for the past 25 years, and another half day with Dr. Anderson, who was elected to succeed Secretary Cox after a service of 12 years as his assistant. Both visits were in the nature of interviews where we submitted questions and they answered. The objective, in practically all of our questioning, was information concerning the present status of National Health Insurance and its effect upon the people, on the one hand, and the profession, upon the other. Perhaps, we could best present you the results by reporting the questions and answers, but as that would be too time-consuming, let us at this moment submit only a summary.

We find existing this state of affairs:

(1) Whereas the medical profession was strongly opposed to the law enacted in 1911, and fought it vigorously for several years, it is today asking Parliament to extend the law so as to apply to the entire population (practically speaking) instead of the 15,000,000 citizens at present covered.

(2) That the organized profession is further asking that the service be extended to include treatment by specialists—the present law covering the general, or the family practitioner only—and to include hospitalization.

(3) A proposed law covering all these extensions was prepared and introduced into Parliament by and for the organized medical profession—the British Medical Association—2 years ago, and its enactment was arrested, and has been held up only because of the critical financial situation of the nation, which so suddenly burst upon the world in August 1931.

(4) We are informed that the 15,000,000 people included in the present scheme, receive *better medical care than before the advent of this plan.*

(5) We found, in that connection, also, that the 14,000 physicians engaged in this work *get paid for their services*—whereas prior to enactment of this law most of that work performed by physicians was not paid for. *It has been a tremendous benefit to the physicians.* Figures supplied by the Ministry of Health—a cabinet position—show that in 1931 there was distributed among the 14,840 panel doctors £6,467,000—an average of approximately $2258 each per annum. Remember, too, that this act permits them to continue in private practice. There is no longer any question that the law has benefited the profession tremendously.

(6) The statement so frequently made here—that the physicians have been ruined, financially; have deteriorated, professionally and scientifically; that the people insured do not receive as good medical care as formerly; and that all sorts of fraudulent practices are perpetrated; were laughed at, and declared to be—in the main—false.

There have been abuses, of course, for, unfortunately, it cannot be said that all members of the profession are honest. The academic degree—M.D.—will not convert a scoundrel into a gentleman. Furthermore, one does not proceed far in an investigation before finding that reports of excessive prescribing, pro-

longation of sick benefits, have been grossly exaggerated by those desirous of condemning the insurance project.

When we asked Dr. Cox whether the medical service to insured persons was inferior to that rendered in private practice—and whether physicians engaged in such work deteriorated —he flashed back—"Is not that question, in itself, an insult to our physicians?" We confessed, hastily, that we thought it was, and, very fortunately for the comity of nations, we were able to show that we had made the same reply to the man who first expressed that sentiment in our presence.

Our final question was—"If the question could be submitted to the members of the British Medical Association today—which would you prefer, returning to the conditions of 1910 or continuing under the present law? —how would they vote?" His answer was— "The majority in favor of retaining health insurance practice would be overwhelming." Incidentally, we submitted that question to some other physicians later, and in every instance, the answer was—the vote would show a great majority in favor of the existing condition; and estimates, when made, ranged from 75-90%.

Chairman: We will now be glad to hear from one of our guests, Dr. T. C. Routley, General Secretary of the Canadian Medical Association.

TRENDS IN MEDICAL PRACTICE; WITH SPECIAL REFERENCE TO NATIONAL HEALTH INSURANCE PRACTICE IN ENGLAND AND CANADA

T. C. Routley, M.D.,
Toronto, Canada

Mr. President and Gentlemen: It is my very pleasant duty, first, to thank you for the honor you have done me in asking me to be here. I am conscious of the fact that it was a very friendly gesture on your part, particularly to invite one from a very small group of people to meet with you as representatives of a very large group of people. But, I am glad to be here.

There are, perhaps, one or two statements that I should make at the outset. As General Secretary of the Canadian Medical Association, my work naturally brings me into contact with all of the profession in Canada. The Canadian Medical Association has never, to my knowledge, made a pronouncement upon *State Medicine,* for or against, and I have, therefore, no authority, representing that body, to make any pronouncement for or against. Indeed, at no time have I ever heard our Council come out in the open and do more than discuss this subject, perhaps each member of the Council looking to the other to make, sooner or later, some pronouncement which would at least offer a basis for serious debate.

Now, there is another observation that I should make at this time. Canada, as a British Nation, functions under an Act of Parliament which was passed in 1867, when our "Federation" became the "Dominion" of Canada. Under that Act, we are a country of 9 provinces and each province was given certain very definite autonomous rights, not the least of which are matters concerning *health* and *education.* So, no national legislation in our country can blanket the entire country with any policy of education or health. I want to make that very clear to you because it may come out in some of our subsequent discussion; each province having the right to legislate for itself in matters relating to health and education. With that preamble, Mr. President, I can proceed.

As I listened to that admirable address by Dr. Reik, I said to myself: "Well, I wonder why he asked me here? In truth, he has stolen my speech, the speech I might have made, almost word for word." But, the extraordinary thing that I pledge myself to you, is this, that there has been no collusion between us. At no time have I seen his notes nor, indeed, have I ever discussed with him what he was going to say; and it would appear to me, Sir, that perhaps he just wanted, and hoped for, confirmation of his observations. I am reminded of a little story, a picture from human life, where an old negro mammy, weighing 200 lb., is standing on the street corner selling from a big basket of oranges, and announcing that these are beautiful oranges, 3 for 10 cents. There is a little pickaninny standing just beside her, with a small

basket of oranges, and the little one shouts—"Me too! Me too." I am in such a position this morning, and I think you will see that I will just be saying—"Me too!"

With your permission, and risking repetition, I shall race over some of the notes I have made. The National Health Insurance Act in Great Britain came into force approximately 20 years ago. Between 15 and 16 million workers are insured. This is compulsory for all workers earning $1250 a year, or less, and the funds are contributed by the State, the employer and the employee. My personal observations are based upon a 1200-mile motor trip through Great Britain during this past Summer. The insured party gets medical services; sickness and disablement insurance; and maternity benefits; by a lump sum. This scheme applies to England, Wales and Scotland, but not to Ireland.

The physician must give medical attendance; proper and sufficient medicines; a limited number of medical and surgical appliances; and furnish, when required. certificates of illness and incapacity.

Every qualified, registered physician is entitled to treat insured persons. All he has to do is to indicate, on a form, that he wishes to do National Health Insurance work. Between 16,000 and 17,000 physicians are thus engaged. When the scheme started, practically all the doctors stated they would not participate. In short order, however, 10,000 had signed up. The Government first offered them a capitation fee of 6 shillings a year per insured person. The doctors said No, and finally got the fee up to 8/6 (8 shillings and 6 pence). The fee fluctuated during the World War period. A Royal Commission reviewed the whole situation not long ago, and now the doctor gets 9s. per head per year.

When the British Medical Association Officers went to the Government to protest they were asked—"Who are you?" "We are the British Medical Association." "Whom do you represent?" "Well, a few thousands of doctors." The politicians laughed, and said that their political power was nearly zero. I just pause to say to you, and to myself, that when governmental agencies attempt to do something, and we go into conference with them, we will immediately be asked whom we represent; and unless we have all the doctors behind us, and educated to the true sense of their responsibilities and their duties, we cannot accomplish much. That is something that, as officials, we must bear in mind.

In 1926, a Governmental Commission reviewed the whole situation and raised the doctor's fee to 9 shillings per insured person per year.

The *organization* required for a doctor and a private patient, resolves itself into 2 persons—the doctor and the patient. When a third person, or entity, comes into the distribution or supply of medical services, a new mechanism has to be set up, and it may vary all the way from 3 people to what we find in Great Britain, namely, a highly organized and complex mechanism with committees galore. There is first, the Borough, or Local, Insurance Committee—a large but representative group. Then there is the *Panel* Committee; the *Allocation* Committee; the *Advisory* Committee; the *Complaints* Committee; the *Approved Society* to which the insured belongs; the Local Medical Society; the *Local* Health Officer; the *Regional* Health Officer; the Deputy Minister of Health; and finally, the Minister of Health—a Cabinet Member. That is starting at the periphery and working in to the center. Naturally, all this machinery costs money, and this must always be taken into consideration when considering any plan for the control or distribution of medical services. *But, with all its defects, the vast majority of the panel doctors in Great Britain would not go back to the days before 1912.*

The British Medical Association, through Dr. Cox, advised me that National Health Insurance in Great Britain had been a God-send to the medical profession; and particularly has that been realized in times of industrial and economic depression. Right now, if you were to ask for a plebiscite on the subject, over there. I venture to say that the vote of the Doctors would be overwhelmingly in favor of—not only the continuance of the scheme, but—its extension. *Indeed, the B.M.A. has recently (1930) promulgated a plan for complete medical service.* Permit me to read a statement of their reasons:

(1) That a satisfactory system of medical service must be directed to the prevention of disease no less than to the relief of individual sufferers.

(2) That the medical service of the community must be based on the provision, for every individual, of a general practitioner or family doctor. (We cannot emphasize that too strongly. The issue in regard to the practice of medicine is somewhere in a basic scheme, a family doctor for a family patient. If we break or disturb that, then our whole structure is in grave danger of breaking down.)

(3) That a consultant service and all necessary specialist and auxiliary forms of diagnosis and treatment should be available for the individual patient, normally through the agency of the family doctor.

(4) That the interposition of any third party between the doctor and the patient, so far as actual medical attendance is concerned, shall be as limited as possible.

(5) That as regards control of the purely professional side of the service, the guaranteeing of the quality of the service, and the discipline of the doctors taking part in it, as much responsibility as possible should be placed on the organized medical profession. (What is the organized medical profession? Whom does it represent in your and my home area? If there ever was a time in the English speaking world when organized medicine had a job on its hands it is now, and are we organized?)

(6) That, in any arrangements made for communal, or subsidized, or insurance medical service, the organized medical profession should be freely consulted from the outset on all professional matters by those responsible for the financial and administrative control of that service.

(7) That medical benefits of the present National Health Insurance Act should be extended so as to include the dependents of all persons insured there-under and entitled to medical benefit.

(8) That every effort should be made to provide medical and nursing service facilities in institutions (Home Hospitals) where the family doctor may treat those of his own patients who need such provision and who can thus remain under his care. (The question of the open and the closed hospital is something for us to think about.)

Now a few points regarding the service. Every insured person is entitled to treatment. The insurance doctors in an area have collective responsibility. A doctor has a panel—not more than 2500, preferably less. He may refuse (or choose) his patients. He may have some *allocated* to him; meaning that a number of patients have not made a choice and they may be allocated by a committee of doctors which deals with that problem. You may say of a man who has chosen you: "I don't want that fellow." Another may say: "I have nothing against him", and he is taken by the latter. The insured, when on a panel, cannot change under a period of 6 months. The insured person holds a card which is his *entré* to treatment. It is the doctor's duty to render treatment to other doctors' patients, in an emergency. The insured is entitled, always, to prompt treatment, no matter where he may be. He is also entitled to your personal service, if he is on your list. You are responsible for your deputies.

Now, what is the scope of the service or the treatment? "All proper and necessary medical services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess." The above is open to liberal interpretation. Each case must be considered on its merits. There must be no leaning backward by the doctor. So far as is humanly possible he must go on rendering service. The unusual services to be rendered are: Vaccination, if asked for; arresting hemorrhage after teeth extraction; tapping a hydrocele; removal of cyst; removal of fibro-adenoma from breast; operation for cellulitis; removal of foreign bodies—needle from hand or foot; treatment by freezing with carbon dioxide—a wart or mole; amputation of hammer toe; taking of blood for a Wassermann test.

Services not held to be within the meaning of the Act are: testing eyes by refraction; removal of varicose veins; removal of an

epulis from between the teeth; removal of hemorrhoids; treatment of chronic rheumatism by radiant heat; ultra-violet ray treatment.

You will note the ins and the outs. Constantly, the general practitioner is called upon to *use his best judgment* to decide whether or not he should treat the patient—and the Ministry expect him always, in case of doubt, to treat. No doubt that is a reasonable view to take.

The doctor must not under any circumstances charge one of his panel patients, *but* the burden of proof is on you if you do perform *what you consider to be specialist service, to prove that* to the Insurance Committee, and if satisfied, the Committee will order that you be paid. If specialists' treatment seems indicated, the doctor must advise the patient what steps should be taken in order to secure such treatment.

The doctor is required to maintain proper *surgery* (meaning proper office) to receive panel patients, and the doctor must visit panel patients at any time and at any place within the limits of jurisdiction of his panel. Visits are to be made without being called, just as in private work, if the condition of the patient warrants it. They have succeeded in cleaning up some offices. I will say nothing about your country but I have been in some offices in my country that needed cleaning up. I have heard men say: "You are always at the beck and call of the patient." The Government says only: "Use your best judgment and we will support you."

If the doctor undertakes to perform an operation, he is obliged to supply an anesthetist who, in all probability, will be paid from insurance funds. The doctor supplies ordinary pills and bandages required, at once. Prescriptions are filled by the Pharmacist on doctor's order. Chemists (English for pharmacists) have to provide adequate and necessary drugs, at costs which are approved by the Ministry. The use of *patent medicines* is not approved, as a general rule. This has much virtue and merit. What would we give, if we could rid the country, yours and mine, of certain nostrums which are a menace to society!

In the matter of *certificates,* the doctor must not issue a certificate unless and until he has personally examined the patient. He cannot issue a subsequent certificate without another examination. Doctors' certificates are accepted as authority for "incapacity" payments, etc., and, therefore, are expected to be reliable under all circumstances.

In cases of pregnancy, when certificate is issued, a woman is not asked to undertake lighter work; even though she may be capable of it, she is excused entirely—a humane consideration.

The doctor is required to *keep and furnish records,* and to afford the Regional Medical Officer access to them at any time. This is a good law and makes for better service and more accurate diagnosis.

Payment for services. All moneys are paid into a central fund and then divided among the Insurance areas. This becomes the Practitioner's fund. Accounts are settled quarterly. Each name on your panel is a *unit* and all units in a borough are counted—say 30 doctors, each with 1500—45,000. The Borough received £5000. It deducts for overhead, special services, etc., £100, leaving £4900 to be divided 45,000 ways; and each panel doctor receives *his panel count multiplied by the unit of money available* for that quarter. It should work out at 9s. per head; plus extras for special supplies; mileage in some areas; anesthetics, maybe; temporary patients; etc. The country doctor who supplied drugs (no pharmacy near) receives 2/6 per head, of his panel, per year. For 2 miles and under, there is no mileage payment; over 2 miles, in approved areas, 1s. a mile, more or less, may be paid. Records must be carefully kept.

Complaints. An elaborate committee plan is set up for this. As a rule, the doctor is exceedingly well protected. Legal representation, is not permitted on either side; to the doctor or the patient. The hearing is private, in the Panel Committee. Disputes between doctors go to the Panel Committee. All members of the Panel Committee are doctors, and ¾ of them must be "insurance doctors", i. e., friendly to the cause.

Disciplinary action. Removal from the list is not done without extreme cause.

Retirement. On 3 months notice one may quit panel service, and no questions are asked. He may sell out, on similar notice. Your panel patients have 1 month to decide if they want another doctor; otherwise, they *remain with the practice;* i. e., become patients of the doctor buying your office and practice. And, curiously, the great majority *remain on the panel* though the doctor changes.

The B. M. A. is now committed to Health Insurance. A vast majority would not obliterate it if they could. At least 90% of the doctors who have done insurance practice, are satisfied.

A word about the service. I believe that the quality of the service being rendered is not adversely affected by the manner of payment. The quality of service rendered must, of necessity, be affected by what I call "humankind factors". Obviously, a busy panel practitioner, seeing 75 patients in 2 hours, cannot give each a thorough examination. The panel doctor says, however, that he gets to know his people, and rarely does a misfortune occur because of his being pressed for time.

The intervention of the Approved Society, the Workman's Club, appears to me, to be redundant and unnecessary, although in the organization of the scheme these societies appeared to have to play a part. With hindsight, a nation entering upon such a scheme need not use such societies. The workman says, "that is my legal defense"; but, that should not be considered favorably, as a part of the scheme set up in any other part of the world.

I had intended to offer a few observations on what is going on in Canada, but I know the time is limited, and perhaps in discussion, if you want to hear something about that, I can develop it at that time.

RESUME OF THE WORK OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

John A. Hartwell, M.D.,
New York City

Mr. President and Gentlemen: I do not, in any sense, represent the Committee on the Costs of Medical Care. I have only followed the Committee's work, as all of you have done, by reading its reports sent out from time to time.

I was asked about 2 weeks ago to review an advance copy of the report and to speak at the time it was presented formally at the New York Academy of Medicine. I have had very little opportunity to study it more than you all have done and, therefore, I feel that I am quite inadequate for the task of really analyzing this report, covering something more than 200 pages.

I think that I accepted this invitation with the idea that a *mediator* is needed at the present time. As you probably saw in the daily press the day after that meeting in New York, there was precipitated a very distinct cleavage of view-point, and that cleavage was apparent also at the Academy between the majority and the minority reports. Unfortunately, there appeared in one of the New York papers a statement to the effect that one member of the Committee had said: "All right, if the medical profession is looking for a fight, they can have a fight to the finish, and we are already collecting the money for that purpose." To argue, in any such frame of mind as that, will not get us anywhere.

Listening to the 2 addresses that we have just heard, I find myself in the very unpleasant position of being a prophet, as compared to being an historian. These gentlemen have spoken of something that has already happened, and has passed through 20 years of experience. They can tell you what has resulted therefrom. What we have to do now, is to prophesy what is to be done here and hereafter. I received Dr. Reik's invitation to come here only 2 or 3 days ago, so have had no time, even if I had the information, to prepare a formal paper but I have studied the report as thoroughly as I have been able to do in the time at my disposal, and I can present several comments that may be of interest and may set you to thinking. I believe, as was so forcibly brought out by Dr. Reik, that *it is time that the medical profession should think,* and it is certainly you leaders who should start that thinking in the right way.

I had occasion recently to write to Dr. Wil-

bur and received in response: "In so far as the report is concerned. it seems to me that there are certain phases of it that are taken too seriously. The proposal of the majority group is—to experiment in certain communities, not to involve medicine in the meshes of government. * * * If the experiments are not pushed by members of the medical profession, it is quite evident they will not work out. If nothing is done, decision for governmental action will be forced, as has been done in other countries, before the necessary groundwork has been laid. So far as the minority report is concerned, I see no reason why that should not also be put into operation. Simply to present a report means nothing unless the constructive factors in that report are given a test. If we could get samples of both methods of approach at work we would soon be on our way to some kind of settlement. It is a good time for every serious minded physician to look the whole situation in the face, and to use his brain instead of his gizzard in working it out."

Analyzing the report, I think it is quite evident that the Committee, although it has not said so, at least not that I have been able to find, has presented a document, full of so much fact, and so concretely expressed, that it is exceedingly difficult to be sure that something has not been overlooked, even in a fairly careful study. So far as I have determined, the Committee did not point out the fact that what they are really concerned with, is that group in the community, in the country, whose members are neither rich nor poor, but who are in ordinary financial circumstances, are self-supporting. and pay their way and do their share toward carrying those below them, but who, when it comes to time of stress and sickness, cannot stand the gaff. The majority members do not sufficiently emphasize that point, I believe, and it is my feeling that in working out this problem we should divide the subject into 4 rather clear-cut divisions: (1) The public health aspect of it. Now, there is a certain clash between the majority and the minority regarding that phase of the subject—not serious. however. Both are agreed that the public health interest must be looked after. (2) We must provide for a system whereby those who are financially able to pay for all of the exigencies of illness may still pay by private arrangement with their private doctor. That is exceedingly important, for that is the backbone of our private practice. Unless the doctors are hampered in some other direction by restrictions, they will go on dealing with this practice on the so-called sliding scale basis satisfactorily and give good treatment and be properly paid therefor. (3) The group we are particularly concerned with embraces the persons of whom I have just spoken. and with which the report largely deals, but it does not make it quite clear that it is *specifically concerned with them;* the persons of limited income, the industrialists, the so-called "white collar" people, who are just on the border-line, where they *can pay something* for their medical care but no so much as they have to pay now under serious conditions. (4) Then, there is the group of self-supporting individuals working as day laborers who can pay practically nothing and become almost a member of the last group, the purely indigent, when they become ill. Now, it seems that a confusion of these different questions clouds the issue, and I should like to call your attention to the fact that, in thinking it over, it will be wise to think of it in terms of the different factors that are involved.

What started this study? It was a realization on the part of the people, as a whole, country-wide, that it is an advantage to the country to have a state of good health of its citizenry, and the question arose; is the country getting it to the extent that it should? Certain people feel—and I think Dr. Wilbur's letter indicates it—that the question has excited rather too much seriousness. It is not so bad as certain parts of this report would lead us to believe. *It needs to be adjusted, but it can be adjusted if we tackle it properly.* If we do not, it will be maladjusted.

What do we mean by *adequate care?* This report, in many instances, is written as though that was a concrete thing that you could describe, and could say that this particular thing was good or bad, and that result is favorable

or unfavorable, but if any one of us attempts to evaluate our own medical service, it is difficult for us to say wherein we have done the best work; where the work has been "not so good"; and where we have actually failed. Trying to lay down a unit by which we can estimate a medical product is very difficult.

I have taken this report of about 200 pages, and have selected some 80 pages in which the recommendations of the *Majority* and the *Minority* agree, and it seems to me that the best function the medical profession can furnish at the present time is to bridge the gap that is already forming; and it is in the hands of you gentlemen who have influence to see that this is done. A friction of heat has already actually been generated. I have talked to many of my personal friends in New York, men at the head of hospitals, leaders in education, and they have been so insistently indignant at this whole thing, that it is frightening. One man said: "A million dollars is just thrown away." Another—a Professor of Surgery in one of our largest institutions, but not in New York—said: "That is a puerile report." Now, I am quite certain that none of those men has studied the report, or even read it. They have taken what they have read in the news-papers, and you know what that means. It is necessary to study this report, and to do that you must give a good deal of time to it.

I would like to take a few moments now, trying to show that *there is really very little divergence of opinion between the Majority and the Minority in this report;* and I am quite confident that if those 2 groups had submitted those reports in conference to a judicially minded man, preferably a doctor, but possibly a lawyer and an analyist, we would find that they are not nearly as far apart as the publication seems to indicate, and the morning press would not have been able to put out such headlines: "Socialism in Medicine; Doctors in the Fight."

Under the recommendations of the *Majority* the opening sentence is this: "The plan for satisfactory medical service outlined in Chapter III can best be attained, the Committee believes, by a process of evolution." They have nothing revolutionary in that. "The growth should come mainly from existing institutions and organizations. In fulfillment of its accepted responsibilities, the Committee states in this Chapter its concrete recommendations for the attainment of satisfactory medical service." The Committee goes on to state its philosophy and intent in preparing these recommendations.

Some of the "recommendations vary in scope, and in immediate applicability. Some are applicable only to urban areas; others only partially solve the problem". "Some of the recommendations could be applied immediately, whereas others must await further evolution of medical practice and the development of an informed public opinion." Now, that is practically the only word that I can find in this report about an informed public opinion and, after all, this is an undertaking in which there are partners—the medical profession and the public that is going to be served, and the government standing on the outside ready to take a hand if it is not satisfactorily done. Very much that is in this report cannot work until the public gets a different point of view, and until you can get coöperation with the public. I believe it is just as important to spend a good deal of thought on what attitude the medical profession will take toward educating the public—as to what all this means—as it is to educating ourselves. I will mention that more particularly in regard to specialization.

"The interests of the 1,100,000 persons in the United States who furnish medical service, and the 123,000,000 who receive it, are closely interwoven." There ought not to be any clash about that. *These quotations, mind you, are all from the Majority report.*

"'Although too great decentralization of authority limits competence and threatens economic effectiveness, too great centralization of authority in any plan carries with it elements of ultimate weakness." That is one of the attacks that has been made on the report, that it will decentralize and destroy everything. Others say that the report wants too much authority. Well, here is what the Majority report really says: "Fortunately, we have re-

tained in this country a wholesome local responsibility for medical service. This fact means that opportunities exist for trying out many plans under various and variable conditions. * * * The Committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results."

Recommendation I. "The Committee recommends that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician." It was that, which particularly aroused the ire of the Editor of the Journal of the A. M. A. If I may be permitted to say so, I think Dr. Reik's closing remarks in his article, published last Summer, concerning the situation as he saw it, are much more to the point; namely, that "the situation needs attention". The best way to move, is not known, but it is something for the medical profession to decide, and it will not be decided unless the profession gets to work on it. As Reik pointed out, there is probably well over 50% of the medical profession, among them some of the leaders in that field, who are apparently not interested, and who have not given it a serious thought. Dr. Routley spoke of *organized medicine*. This is the time when medicine must be organized. We cannot solve this problem by exhibiting differences of opinion to such an extent as to cause an immediate riot. Without our intervention, I have an apprehension that a riot is going to occur.

"The development of group practice carries serious hazards." That is a statement from the *Majority*—those who advocate group practice. "The most serious of these is—that the quality of medical service may be adversely affected, either through the internal arrangements of the group, or through the relations between one group and another." There, surely, is no issue between the Majority and the Minority. There is no point in saying that the medical profession is going to fight this thing. That just beclouds the whole issue and destroys our usefulness.

Recommendation II. "The Committee recommends the extension of all basic public health services." There is a certain amount of real difference of opinion there. How far shall the state or the local government go in public health matters? We recognize that we do not want quarantine to break down, or our water supply and milk supply polluted. We recognize that we would be glad to get rid of diphtheria. Do we recognize that we should give the government a hand in getting rid of diphtheria? The experience in New York shows that there is a good deal of difference of opinion as to how far the public health service should go in that matter. They are striving to give authority to the doctors. Certain instances have been found where private physicians refused to look after children brought to them for the necessary tests. They are not alive to their opportunities to keep this out of governmental control.

The *Majority* recommends that the health activities be increased; the Minority says—they should be kept down to the present status. I trust Dr. Morgan will correct me if I am wrong. Whatever helps toward improving the health of the community, the health department should have a hand in; but in doing so, it should preserve the status of the medical profession.

Regarding payment, the plan of the Majority recommends so-called *hospital centers* being established everywhere; I am assuming that you are familiar with the high spots in this report. It makes the statement that "The population as a whole can pay for adequate service without hardship. In fact, to a certain extent good medical service pays for itself in prevention of disease and in increased efficiency and productive ability." Now, the population as a whole can pay for adequate service but it must be distributed throughout other groups than those that actually need it and are paying for it. It is in an attempt to solve that problem that they have laid down this *group practice* idea.

The Committee Majority hangs half-way between putting this on a *voluntary* or *compulsory* insurance basis. It is not ready to go to the extent of having a compulsory insurance at the present time, but feels that it will probably evolve later; but they propose doing it by a voluntary method to start with. As the *Minority* report points out, it is very doubtful if the policy as a whole will work satisfactorily, because a large number of people who need this type of insurance, namely, the kind that have been insured in England, may not be willing to pay the necessary amount voluntarily. The Committee estimates it as something between $30 and $35 a year for each individual. Now that is all right, but if there are 5 persons in an individual family, that rate would run to something over $155 a year, and if the head of that family is making $1800 a year and does not have any sickness he will question whether he should take out that insurance. The Majority feels that we had better go through that phase, and try it out, but that we will eventually come to compulsory insurance, somewhat on the basis that exists in England.

"Sound public policy demands that the practitioners, as well as the agencies which provide such service, be properly remunerated." The Majority Committee have in mind that the doctors have been improperly paid and that they ought to be better paid. Then it goes on to say that: "None of these recommendations involves an untried experiment. Everything recommended exists somewhere in the country." I would like to read this dissenting note from some of the Majority Committee: "'We call attention to these significant statements embraced in the body of the report. Fortunately, we have retained in this country a wholesome local responsibility for medical service. This fact means that opportunities exist for trying out many plans under various and variable conditions. * * * The Committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results." These dissenting gentlemen say: "We believe that experimentation along the lines of both voluntary and required health insurance, along with the other experiments in the group purchase of medicine, should be promoted and carried on. In all likelihood, in certain areas of the country and for certain population and economic groups, required health insurance will be found to be more feasible and practicable than voluntary health insurance, or vice versa. Therefore, we feel that the report should not emphasize or recommend voluntary health insurance over required health insurance but that both plans or a combination of the two be equally recommended by the Committee for experimentation." This is signed by Haven Emerson, Elizabeth Fox, John Sundwall and Henry C. Taylor. In other words, part of the Majority Committee had the same view as is expressed in the Minority report. They say: "It is very desirable to develop strong, organized professional groups, each rendering comprehensive medical service, before insurance becomes compulsory. If health insurance is to operate successfully, it must cover all forms of illness and include preventive as well as curative care. * * * Such an end can be attained more readily when the medical service is rendered by organized groups than when rendered by individual practitioners. * * * European experience, particularly in those countries like Germany and Austria which have had comprehensive insurance plans for many years, shows that serious evils of competition and price-cutting may exist under a compulsory plan and, if so, are difficult to eradicate." They recognize the weakness or danger of their own plan. We should not feel disturbed if we cannot go the whole distance with them.

Both committees are agreed on this: "The Committee recommends that the study, evaluation and coöordination of medical service be considered important functions for every state and local community, that agencies be formed to exercise these functions, and that the coordination of rural with urban services receive special attention." There is some difference of opinion as to how this should be approached. The Majority wants medical bodies, with lay assistants, to take the lead; the Minority wants it left entirely to the county societies, as I understand it. I am not in-

formed as to how well the county societies throughout the country are organized to undertake this work. Those county societies with which I am most familiar, I do not believe are organized to undertake it; because they change their officers frequently and it is difficult for them to visualize a program so extensive as this. It has been tried, as you know, in Iowa and seems to be working out well. There may be many counties where it could be done well, but will it not be tried there in one way, and be tried in some other place in another way? They recommend: "That there should be set up in each state a permanent, organized agency for the study of the problems of medical care. Such a body should include representation from the public, from the medical, dental, nursing and pharmaceutical professions, from the public health services, the hospitals, and the voluntary social agencies." It does not say how they want that body created, whether they want the state to take part in it or not.

This is emphatically stated: "The physician is the basic factor in any plan for medical service. Some of the present difficulties of medicine, such as the over-supply of specialists and the poor services furnished by some general practitioners and by some specialists, with the consequent increase of costs to the patient, are caused by the character of medical education, and by the fact that many physicians cannot or do not carry on post-graduate study." They speak of the limitations in medical education and their recommendation is this: "That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; and that post-graduate educational opportunities be increased." It continues about the education of dentists, pharmacists, etc. They speak of the trend of education for the practicing doctors, both the family physician and the specialist. That seems to me a very serious lack in the planning of their program.

Those are the outstanding things that I marked down as I studied this report pretty carefully. In the Majority report it is stated that: "The public should recognize a central group in determining standards and methods." In other words, they are just as insistent as the Minority on the fact that the doctors must stay the center and the guiding factor in this whole affair, as was pointed out by Dr. Routley, but they give the impression, in their recommendations, that they are going to do something which will hamstring the medical profession and, as a result, the A. M. A., if you can judge from its editorial, has taken much the attitude that the B. M. A. took in 1911. It is necessary to recognize, in this country at any rate, that the thing is now on the move. The A. M. A. says editorially that it was largely fostered by Mr. Filene, of Boston, abetted by Evans Clark, and carried on by Dr. Moore, and that the report has a definite bias and should therefore be fought by the medical profession. Suppose Mr. Filene did have the idea, suppose he associated with himself Evans Clark—and I know he has a strong feeling for this thing—and Dr. Moore has also had an interest in this matter; it is not those men but the idea, about which we are concerned. We have heard a description of it as it has worked in England over a period of 20 years and it does not sound so bad. It may not be at all applicable here but it is certainly worthy of our serious consideration.

Here are the issues in the Minority report that I want to call to your attention and to show you how much they are really in accord: "Many educational improvements are under way through the initiative of the medical and dental professions and college authorities. Among them one of the most important is the increasing emphasis upon the necessity for more thorough training of the general practitioner in all of those fields which only he can adequately fill. In this connection we call attention to the fact that neither scientific medicine nor the organized professions have been unprogressive. * * * The general trend of the Majority report makes it appear that the medical profession has been static and unprogressive." I do not find that suggestion in the Majority report. They have named all of the things that we have done. The Minority report goes on to say: "This implication we believe to be unjustified by the history of

medical progress." I agree, but I do not see that in the Majority report.

Those of you who are connected with teaching institutions must have observed a very strong trend toward an education that eliminates the family doctor. More and more are our students being trained in some special field. As Dr. Libman pointed out at the Academy some days ago, nearly every Professor in our large teaching institutions has a certain bent in his activity and he hands that bent on to his students so that they fail to get the *rounded-out* training that we got formerly. I think that is a perfectly just criticism. I have been observing in one of our teaching institutions—in attending the clinics where the students are being taught—that many of the students haven't the faintest idea of going over a patient thoroughly and learning all they can about him. They look in his throat and, finding that the tonsils look a little inflamed, he is referred to the Department of Laryngology. Or finding that a patient 60 years of age has to get up during the night, to urinate, he is referred to the Department of Urology. They do not make use of the things that every doctor can use, but they get a specialistic training while they are still under-graduate students, and by the time of graduation they have centered their minds on something that they are to do as a specialty. That sort of thing must be corrected. I talked with the Dean at Cornell about it and he said: "Certainly, we recognize it and must cope with it." The practitioners, themselves, lose an enormous opportunity for building up a family physician prestige. They do not take the trouble to give the simple treatments of the throat or the ear or the bladder or the rectum, but, themselves, send the patient off promptly to some one else, and then complain that they cannot build up a family practice. The public, as you know, has begun to take things into its own hands and many people pass over the family doctor, thinking thus to save his fee. That is a trend that we must set our faces definitely against. This is more important, in regard to putting the family physician out of business, than is any plan for setting up group practice, in my estimation. I believe, therefore, that we must begin in the medical schools and train these students as family physicians, keeping their minds on the fact that they are going to treat all parts of the body. Until they have finished, not only the medical school but an internship, they should not think of going to work in any particular, limited field. The public begins to want this, and I believe we can get the family physician back in that way. I am constantly being asked where a family physician can be found who is not too busy to take care of a patient. It is almost impossible to answer. All of them are engaged in some specialty at a very early date after graduation.

Regarding contract practice the Majority report says: "It should be remembered that the medical profession does not object to contract practice *per se* but only to the unethical practices which may attend that method of rendering medical services." It is our business to see if there is something in contract practice, and if we can eliminate the evils.

Further, in relation to group practice, the Minority Report says: "This injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service." I think that is a statement that cannot be substantiated, and I fear such remarks are drawn from an active imagination and are not based on careful thinking. Plenty of these things, in both reports, might better have been left out. It does not seem probable that group practice, in the insurance form, is harmful to the medical profession and to the public. I know, from my experience at Cornell Clinic, where we have a definite group practice, that such results do not follow. The doctors work just as hard there as they do in their private offices, perhaps harder, and more carefully, because they are in close competition with other men who are observing them and their work. So, I feel with Dr. Reik, that it is an indictment of our profession if we charge that, because we are associated together and are paid by a fixed salary, we will become either careless of action or less interested in the patient's welfare. I think the type of work done under Health Insurance will be quite as good as we have ever done in private practice.

Here is one of the main features of the whole thing: "Privacy and the personal relationship

which should exist between patients and physicians are broken down." I cannot quite see why that *need* happen, *must of necessity happen,* in any form of practice. Referring again to the Cornell Clinic, the patients there become just as much attached to their doctors as they do in any private office. They have frequently requested that they be allowed to retire from the Clinic to become the private patient of a particular physician, as they "can now afford to pay" for it. If properly managed, I do not believe that the private relations between physician and patient will be disrupted. I can see that the other side of the question might be visualized. How many industrialists, how many laboring people, how many of the so-called "white collar" class have much freedom of choice in selecting their doctors, and how do they get them? They ask some friend, generally, whom to consult. They get some one "wished on them" almost as frequently as does the fellow in the clinic.

I want to state again that it was utterly impossible for me to make a complete analysis of this Report. It is entirely too long and too full of subtle facts and suggestions. There are 2 main reports—the Majority and the Minority—or at least, 2 sets of *Recommendations.* Those have caused a clash, and I have tried to read certain sections from each to show you that *the actual difference is not very great.* I think there is, in fact, *no fundamental difference.* I think certain of the gentlemen are scared by certain possibilities, and feel that they had better not subscribe to the Majority report, as written. My sympathies are with them to a large extent, but I think that both groups have the same thing in mind, essentially, and that you gentlemen, representing the state organizations, should do your utmost to arrest this division of opinion right here, for it is going to grow dangerously if you do not, and if more editorials are issued like the one that appeared in the Journal of the A. M. A. The medical profession will be divided, which would be much more harmful than having something from outside foisted upon us. We can stand united, and act as a unit if we will give proper thought to it; because there must be some solution, and it only requires some head work to find it. But if we merely denounce the statements of others, or say "that report is puerile", as did my friend in New York—and I venture to say that he had not read 10 pages of it—we will not help much toward the solution desired. *The whole profession has got to give this matter serious thought,* as Dr. Reik pointed out nearly 2 years ago.

One final word. We do not want something "put over on us" by outside influence, and probably the majority of the people in the United States are quite well satisfied with medical practice as it is, but we know from sad experience what a minority can do, in this or any other democratic country. We have had several things jammed down our throats—one of which we are about to vomit up again—by an organized minority. Now, there is a minority which is attempting to do something that may or may not be sound, and we have got to gird up our loins and find out the proper and the sound solution, and then place our faces definitely against any wrong movement.

Luncheon was served at 1.30 p. m., at the Hotel Chelsea.

Resumption of meeting at 2.30 p. m.

Chairman Lippincott: Trusting that you all feel refreshed, I will call for the next paper, a "Résumé of the Work of the Committee on the Costs of Medical Care", by Dr. Arthur C. Morgan, of Philadelphia.

Dr. Morgan: It is indeed a pleasure to be back once again with this Conference group. It has been my privilege to have been for 5 years associated with the group, which is ever changing, ever new, and yet attended continuously by friends of old.

I have been asked to speak with special reference to the *Minority group report,* as I had the honor to be among the dissenters to the Majority report. The final report, as submitted publicly, represents many changes, additions and deletions from the original draft that was proposed a year ago. In reply to Dr. Hartwell's comment that—had the differences been submitted to a judicial committee many of these differences would have been ironed out, I want to put myself on record as

saying that the final report, as submitted was a dangerous document to flaunt in the eyes of the public at the expense of the medical profession. The members of the Minority group under their able leadership of Dr. Follansbee, of Cleveland, and of Dr. Arthur C. Christie, of Washington, filed their objections in such masterly manner that they were accepted in toto, almost without the change of a word or a letter.

It was not my privilege to attend the first meeting, in Washington in 1927, but I have since attended all but 2 or 3 of the general sessions of the Committee. From the very start, Dr. Wilbur has constantly pointed out that the family doctor is the key to the situation, that all of our work and thought and constructive energy must revolve around the family doctor.

Dr. Hartwell's closing remarks today epitomize, I think, the sentiment of the vast majority of the physicians in this country. He has just said, in our presence, that we do not want anything "put over" on us (the medical profession) from outside sources. Now, gentlemen, that is the key to the basic structure of the Minority report from the Committee.

At a general meeting held in July, a Committee was appointed, with Dr. Van Etten as Chairman, to give us a definition of the personal relationship between physician and patient. It is: "That relationship which includes not only the privileged confidential communications of patient to physician, which are recognized as inviolate by law, but also the relationship involved in the communication of his medical history to any physician chosen by the patient and the continual mutual responsibility between patient and physician." This in no way inhibits the patient from giving his confidence to different physicians or to a group of physicians. The business relations between physician and patient are not considered to be a necessary part of the personal relationship as defined, nor does the definition carry a commitment for or against any scheme of organization of medicine. "Contract practice" was defined exactly as formulated by the Judicial Council of the American Medical Association, as follows: "The carrying out of an agreement between a physician or group of physicians as principals or agencies, and a corporation or organization or individual to furnish practice or render medical service to a group or class of individuals for a definite sum or for a fixed rate per capita." I just want to remind you that for 5 years these men, who had been engaged by the Committee, were floundering around, trying to determine the ultimate outcome of their studies. It reached a climax because of Dr. Follansbee's insistent projection of this proposition, with the result that this definition was evolved after the final report had undergone 3 revisions. I am personally of the opinion that the Committee, resolved itself into 2 groups: one of which considered members of the medical profession as pawns to be talked about and handled without relation to the human side of practice, and who viewed the people at large as they would so many standardized parts of a machine; and the other composed of physicians chiefly, and those of the Minority in particular, which always tried to bear in mind that what we were trying to do was—to work for the best interests of the doctor in serving his patient, but always keeping in mind the fact that the patient is a human being.

It is true that the Minority group presented their objections. It is equally true that had not the Minority group presented their objections from the very first appearance of the final report draft there would have arisen cause for a rebellion or a revolution on the part of the medical profession. At the beginning the Committee was named as one to study the *cost* of medical care. In a very short time inquiries, suggestions, objections, were received which showed that the people at large misinterpreted and misunderstood the title of this Committee, so that additions of the letter *s* was made to the word *Cost;* which showed the people, and also some members of the Committee, the many ramifications of *costs* in the care of sick persons.

May I read from publication No. 28, page 166, that is the final report, regarding health insurance as shown by Simons and Sinai, who spent some time in England, France and Ger-

many studying the *panel* and the *dole* systems in those countries: "'Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of health insurance."

I am very pleased that we have our Canadian friend here today. The American, in contrast to the British, is an individualist. Over there, they submit to authority in groups, regardless of Hyde Park on Sunday afternoons. In this country, we still maintain our individuality. It is my personal opinion, based upon some reading and upon conversation with some of my own relatives who have recently come from the other side to visit us, that the *dole system* and the *panel system* probably work fairly well in a certain little coal town; but that if given the same condition of affairs in this country, they would not work out so well.

Dr. Hartwell quoted from page 153 of the Minority report: "In the opinion of the Minority the general trend of the Majority report makes it appear that the medical profession has been static and unprogressive. This implication we believe to be unjustified by the history of medical progress." In the original reports, occurred such flaunting statements in respect to the incapacity of a large share of the medical profession in this country that I felt it to be an insult to the medical profession to permit them to remain. That is one criticism that was completely deleted because of the demands of the Minority.

When the report was released on November 30, the final meeting of the Committee having taken place in New York the day before, which I could not attend because of duties elsewhere —when that Majority report was made known it was on a par with some reports on other occasions. Some little chap will be chosen, and a big report made about what he said or did, and then the crux of the situation is dismissed by the inimitable reporter saying that "so and so" were present. The Majority opinion had the ears of the reporters and the columns of the news-papers of this country, gained possibly by subtle influences, with the result that the Majority report has appeared in rather amplified form, by aid of the great papers, throughout our country. It remains for the Medical Journals, in particular, and for the State and County Medical Societies to secure copies of this report, to assign the report to their Committees on Public Relations and on Medical Economics, for analysis and reports at subsequent meetings. By the time of the next meeting of the A.M.A., in Milwaukee, I am sure that much crystallized thought, and sentiment, and wisdom will have come to us from many men; with Dr. Hartwell as a splendid example of that *sane and safe counsel* which, in the end, will prevail. At present, it may seem that the editorial in last week's A.M.A. Journal was rabid and biased but, Gentlemen, that editorial was prompted by certain causal factors that were active in Washington, which did not brook interference at that time, and did not receive the opinions of the Minority with a free hand, and that was bound to result—exactly as "action is equal to reaction". May I ask for your careful study of the American Medical Journal's editorials for some time to come? May I ask that you take back to your respective State Societies, and to their County Societies, in the last analysis, the study of this important publication, so that we may soon have the views of our home colleagues, not only in the urban but in the suburban and the rural districts; so that there shall be epitomized a fairly comprehensive report to submit to the American Medical Association at the time of the Milwaukee meeting.

I shall not occupy your time any further as I prefer to have the remainder of my time given over to Dr. Leland, who can speak with authority because of his greater familiarity with many of the details of the subject.

Chairman Lippincott: We shall now have a Discussion of the Report of the Committee on the Costs of Medical Care, and of

the addresses delivered today, opened by Dr. R. G. Leland, Chairman of the Bureau of Economics, of the American Medical Association.

Dr. Leland: I am very happy to be here today. The subject of your discussion is exceedingly close to my work. As Director of the Bureau of Medical Economics of the American Medical Association, I have been privileged to see practically all of the separate reports published by the Committee on the Costs of Medical Care, and the several separate successively revised copies of the "final report" including the really *final* one before it was released for publication. I am not privileged to speak for the Association. The House of Delegates, alone, can decide what the attitude of the American Medical Association shall be relative to the Report of the Committee on the Costs of Medical Care. However, there are some things which I believe we ought to study very carefully. I believe it would be to the advantage of every County Medical Society to have a complete file of the Reports published by the Committee. There are a number of things, in several of them, which are worthy of careful study.

It appears from the "final report" that the necessary superstructure of group practice is to be based upon one report which was entitled, I believe, "Group Medical Practice", a report which estimated that there are about 155 "medical groups" in the United States. The conclusions upon which this Report was based, concerned a study of 50 of those groups. The financial conclusions which were cited in the Report were based upon only 27 Medical Groups in the United States. In my office, I have a record of between 600 and 750 Medical Groups in the United States, and I have no idea that they represent all of the Medical Groups throughout all of the States of the Union. I regret very much that the Committee on the Costs of Medical Care did not see fit to make a careful study of one of the most important, and naturally one of the largest, phases of this work, namely Workmen's Compensation, for that kind of medical care is practiced now in every state. In 4 of them it is practiced, to be sure, under the old form of liability laws instead of the newer type of compensation law. Nevertheless, Workmen's Compensation is a tremendously large field of medical practice, involving almost everywhere this type of medical care which we call *contract practice*. Now, the contract practice studies of the Committee, the published reports, are those of the most favorable types of contract practice that can be found. There were 3 of such reports published, among which were the Home State Mining Co. and the Endicott-Johnson Company. For each of those published, probably 100 can be found which are not as favorable in many or most respects.

What I have to say about today *contract practice* is not based upon any theory or academic consideration of the question. We have made a careful study of Workmen's Compensation from field observations. And what I have to say about the newer phases of contract practice is based upon a study that is now being made. Probably in January there will be published and furnished to State Medical Societies—and I hope to many County Societies—a Report on Workmen's Compensation, which will be about as large as the Final Report of the Committee on the Costs of Medical Care.

There has been one phase of the entire question altogether too lightly touched upon by the Committee on the Costs of Medical Care; namely, that were everybody in the United States provided with an absolutely above-subsistence income, the question of the costs of medical care would never have had to be investigated by the Committee. This is not entirely a question of what the medical profession ought to do about furnishing medical care to certain groups or types of the population who temporarily—or some of them permanently—are unable to pay for medical care. It involves a much more fundamental question of whether our people are being paid a *subsistence,* or a *subsistence-plus* income. Apparently, the Committee gave that much less thought, if any, than some of the recommendations pertaining to the medical profession specifically. There are, already, experiments set up in several parts of the United States, some of them approved and ready for operation before the

Final Report of the Committee was published. The California Medical Association has already, before the Committee's Report was finished, approved of a plan which it hopes will be placed in operation in some parts of the State, providing for the care of individuals with an income of $2000 or less annually; offering 3 types of service, medical or hospital care, or both, on a fixed monthly payment basis. What will work in California, may not work in another state. However, the medical profession has started to try to solve its own problems.

There is another experiment which is being formulated in Milwaukee County, Wisconsin. The State of Michigan is making a very extensive study, and has placed in operation some of its plans specifically, one which deals with "care of the indigent sick" in Oakland County.

I believe it was Dr. Hartwell who said something about the number of medical students who are selecting their specialty before graduation in general medicine, as compared with those who formerly made such decisions. It might be startling to some of you to know that probably 75% of the senior students in the medical colleges of the United States, are now determining during their senior year, or even before, the specialty they wish to follow upon graduation.

To be more specific about what has evolved in much of this report, I want to call your attention briefly to some of the things which we have found inherent in contract practice. There is in all medical practice an *implied contract,* but that is not the *contract* to which we refer in the thing which we call *contract practice.* Now, the Judicial Council has recognized, in its study of this subject, that there are certain forms of contract practice which are essential, which are legitimate, and which are ethical. However, there have come into this type of work certain phases which are not very dangerous but which have spread, and have taken on a commercial nature, which if injected are almost sure to disrupt medical organization, and which certainly are making it very difficult for physicians to make a living. Regardless of how we feel about the practice of medicine here in the United States, *we have in these types of contract practice, whether they offer medical service or hospital service, or both, a voluntary health insurance system already operating.* It is not called *health insurance,* for most of these people are very careful to avoid the use of the term *insurance,* but the danger lies in the fact that there is a likelihood that in some places these forms may be carried over from the voluntary to the compulsory type, and as they are, they carry with them all of the bad features of the original voluntary type, such features as misrepresentation of contract; the interposition of a third party between the patient and the physician, or the patient and the hospital. Preventive medicine is disregarded in particular types of contract practice.

I must register a disagreement with Dr. Hartwell about the quality of services rendered in many types of contract practice, which are essentially insurance types. The quality of service, we have found in many instances, is decidedly substandard. Now, to be sure, there are a number of high type medical groups doing contract work, but that is by no means the rule. Frequently, the patient who has something serious the matter with him will employ his own family physician rather than the contract doctor who is taking care of the factory or industrial work. The effect upon the public ought to be obvious. Anything which destroys the confidence of the people in the profession, is, we believe, extremely bad. There is a belief, whether the patient is always conscious of it or not, that the physician of the patient's own choice is the physician who has his best interests at heart. If, because of compulsion of some kind, the patient is required to go to another physician, he at once, consciously or unconsciously, wonders whether this physician has his interests at heart or whether the physician has a stronger allegiance to the insurance company, or to the industry, or to some other group, than he has to the patient himself. It frequently happens that the allegiance of the physician is stronger to the contract group, hospital association, insurance company, than it is to the patient; for this reason—that in the case of any controversy the physician's testimony may be required in

Court, and his allegiance is primarily to the source of his income. Fortunately, not all physicians feel that way about medical practice but there are states among the United States, in which it will be with great difficulty that the practice of medicine can be returned to the older type, and what we believe is the best type, of private individual family physicians. It has gone so far now that it will require almost a miracle to bring it back.

The effect upon the profession is no less destructive and dangerous than it is upon the public. The profession becomes commercialized, first by the interjection of a third party. We believe that it is inimical, to the public and to the profession, that there should be placed between the physician and the patient, a third party making a profit from the medical service which the profession has to offer.

Regardless of whatever scheme we may devise for the better administration of medical service; however ideal may be the conception of these plans; whether we take the plans suggested by the Committee, the plan suggested by California or some other section of the country; these plans are the source of a kind of proliferation. One plan is almost sure to call forth a series of plans. We already have the evidence in several sections of the country that plans devised and promoted by laymen for a profit will be offered to the public as a copy or some sort of substitute for the original. They will be offered at lower rates with the same amount of service, or less service for the same amount of money, or any other combination you wish, but the substitute or the second, or third, and subsequent plans will almost inevitably give the public less service, or an inferior quality of service from that originally intended.

I believe I would not be completing this discussion were I to omit some remarks on a new type of medical service that has been developed recently. About 3 years ago, a hospital in Texas put forth a plan of truly altruistic nature; i. e. to offer school teachers group hospitalization at a cost of 50 cents a month. It was never intended that this plan should assume large proportions or take on commercial nature, but not long after that a commercial organization seized upon the business possibilities in offering group hospitalization to the general public and to employed groups at 75 cents a month; the extra 25 cents being for the promotion and profit of the commercial organization. A short time after that, another commercial organization was started, and this third group has 9 or 10 hospitals already operating. There are now at least 2 commercial organizations in New York City; there is a group of hospitals in New Jersey, one in Philadelphia, another in Boston, I think, and similar group hospitalization plans are being pushed rapidly, especially in the west.

What does this group hospitalization mean? It means, first of all, that the hospitals of this country have admitted, openly, that they have a tremendous financial load to carry and they are trying to devise a means of meeting that financial obligation. These plans are, in many instances, conceived and started as a temporary expedient to meet a financial need. I would like to ask you, and each of you may answer it to himself—what you believe the effect would be, of such a plan, on the physicians and the hospital staffs, who are required to care for certain group contract-covered persons who are unable to pay for medical care? It is conceivable that these contracts may be sold to a certain group of people who are able simply to pay a $10 or $12 a year contract. This plan gives them hospital care but when they come to the hospital they have no further funds with which to pay their physician. Consequently, either the private practicing physician or the staff of the hospital must care for them free of charge. Then, is it necessary that a commercial organization be organized to vend hospital service as well as medical service? And, what will be the ultimate outcome of these plans, commercially conceived and commercially marketed for hospital care? I have already been told by some of the people who are pushing these schemes that just as soon as the schemes become sufficiently secure, so that they will know that they have a fairly large cliéntèle in the community, medical service will be added to hospital service. What is the likelihood in your community of the transfer of such patients to some other physi-

cian who may be practicing in the hospital that holds the contract? Let us say that you do not happen to be practicing, or operating, or a member of the staff of a certain hospital. The chances are that you will lose your patients, and they will go to the physician on the other side of town who practices in the hospital that has accepted or developed this plan. Now that is not a theory. It has already been reported to me as having occurred. Is this type of group hospitalization a cure for one of the very obvious ills of our hospital system today, namely, over-hospitalization? In many parts of the country, I believe it can be shown very definitely that some communities are over-hospitalized. Aside from the fact that during the past few months, or perhaps during the past year or more, some of our people have not had as much illness as previously, there is a grave question whether the sale of contracts will cure the over-hospitalization matter. In some of these plans there is created a *central fund,* and out of such fund the hospital is to be paid, not according to the number of people who choose the hospital as the one in which they would like to be sick, but according to the number of contract-holding people who are sick in the hospital. That *central fund* continues to pile up and what may happen to that fund no one knows; whether it may be dissipated by the failure of a bank, or whether some promoter may get a large enough amount to make it a fairly interesting sum to "get-away-with" is, of course, problematic. But why should it participate in the fund only to the extent of the contract people who are sick? Why should it not participate to the full extent of the number of people who subscribe for the service? There is, of course, some more information available as to the actuarial soundness of the rates charged for hospitalization than for the rates charged for medical care under contract practice. However, there is, I believe, insufficient data as yet to show that the rates charged even for hospitalization are economically sound.

There is a very definite legal side to this whole question. What are the laws in your states pertaining to contract practice and to insurance? Regardless of what we call this thing, whether it is named *insurance* or *hospital care* or *contract practice,* what would the Supreme Court of your state do if a case were taken to the Court under any guise whatsoever? Would this not be called *contract practice?* Would it be called merely the furnishing of medical service as a physician or a hospital ordinarily furnished it, or would it be declared a kind of practice which requires incorporation and certification under the insurance laws of the state? With our ideas regarding the corporate practice of medicine, we should always consider well what form of organization we create to do the things we thing are necessary. Incidentally, that is one of the things that is most difficult for the people in Milwaukee to decide, whether they must incorporate, and whether they will be required to comply with the insurance laws of that state.

Another legal question arises regarding the liability of the hospital in case a peak-load is encountered during an epidemic or some other disaster. Let us suppose that a hospital with a bed capacity of 200, has 10,000 contracts when, suddenly, it is called upon to take care of 400 people; I happen to be a patient and I demand of the Superintendent hospital care, but my hospital is full. I immediately say that "I have a contract which states that I can get hospital care". The hospital insists that it cannot give me this needed care. What is the legal liability of a hospital under such circumstances? I must confess to you that I cannot answer the question today, but I leave it with you to keep in your minds when these plans for group hospitalization come to your communities.

What is the likelihood of starting other forms of hospital care similar to the types of contract practice that have developed in medicine? Already we have probably a dozen or more different hospital groups started throughout the country and more are starting every day. Can you see the competition that will arise in a community where one hospital has a contract service and the others have not? Immediately, there is set up an unfair competition among hospitals, and hospital economics and medical economics are inseparable. This question, as in contract practice, as in

Workmen's Compensation, as in many other phases of medical practice, is not so simple. It is really a very complex affair and it cannot be settled by hospitals alone. Neither can it be settled by physicians alone. They, I think, would come nearer to settling it than anybody else, but I believe this question of group hospitalization should be discussed and passed upon by physicians and hospitals together. We need yet to do a great deal of educating of hospital trustees. We know that hospitals are suffering a tremendous burden right now in trying to meet payments due on bonds for big, new, elaborate, unnecessary buildings and palatial furnishings, expensive and unnecessary equipment, a duplication of which can be found in a number of institutions of the same type in the same community. These things require the combined thought and study of the medical profession, hospital superintendents and boards of trustees. Whether the country at large is going to be stampeded by something new and revolutionary, such as some of the things we find in the report of the Committee on the Costs of Medical Care, remains to be seen.

I have here with me some news-paper comments which are to appear this week in the A. M.A. Journal. This news-paper comment comes from the Washington Star, the Boston Evening Transcript, the New York Herald-Tribune, the Dallas Morning News, New York Evening Post and the Philadelphia Record. I suggest that you read those news-paper comments rather carefully because it is gratifying to see that the news-paper men have grasped the situation. Just let me read you 1 or 2 paragraphs:

"The Report is published at a moment when the people are discouraged. It comes as a fright of the depression. It may be right or wrong but in either case it is entitled to study, but such examination ought to be unprejudiced. Both sides should be considered. It should not be forgotten that the American people are the healthiest people in the world and their period of culture and prosperity was achieved under the American system of civilization, not the Marxian system".

The Philadelphia Record says: "Progressive as medicine has been scientifically, just so retrogressive has it been ethically. The medical profession clings to an ancient code of conduct that does not belong in this age. They have taken inordinate pride in a system of ethics. That is the reason the physicians find themselves in the impossible situation where the majority of them who are serving the community ably and faithfully do not receive an adequate living in return. They must accept the humble business system of ethics according to which the rest of us conduct ourselves. Advancement of medical science demands medical centers and specialists but this does not necessitate bureaucratic control. Medicine must not be socialized".

With all that has been said, the American Medical Association believes that whatever action is necessary it should not be the action of an autocracy or of a Czardom. We in Chicago believe that it is our function to collect data as accurately and completely as possible. That, we are trying to do, and to place in the hands of State and County Medical Societies the collected data. However, the action must be an action from the lowest unit, the County Society. Action cannot be intelligent and cannot hope to meet the questions involved unless every man is informed so that he can act intelligently. The question before us at present, it seems to me, is, as soon as possible, and as accurately as possible, to inform every member of the medical profession as to the exact conditions with which the medical profession is confronted. That being done, whatever solution may result will be much more sane and safe. Whatever we can do to help we will gladly do and we are always at your command.

Chairman: We are certainly very grateful to the speakers of today. They have given us a great deal of material to discuss and the meeting is now open for general discussion.

Dr. William D. Johnson (Batavia, N. Y.): There is an element that has not been represented in this meeting, and that is—just the plain country doctor, who started with a horse and buggy, with direct personal relations with his patients, and who has never wandered aside from that little group of people except to, once

in a while, get into a maelstrom like this and then wonder, like the representative in Congress whom some of you older men remember of 30 years ago, who after a night out fell asleep at his desk, and, being awakened by the sound of the gavel, said—"Where am I at?" He thereby delivered himself of a classic, that will last longer than the records of that Congress. When some one tried to explain that joke to an Englishman he said, "What poor grammar for a Congressman. In my country, we say—'Where is my 'at?' "

It is a curious thing that this whole superstructure has been built up on the point of a pyramid that involves the relation of a patient to his doctor. It shows how complicated a thing may be based upon simple elements. I never could understand the axiom that "things which are equal to the same thing are equal to each other". I cannot understand this question when I go much farther than the relation of the doctor to his patient.

Dr. Walter F. Donaldson (Pittsburgh): I am going to suggest that inasmuch as time is flying, and we have had 2 excellent papers on a certain form of medical practice in England, and have not had much time to hear about several forms of medical practice in Canada, that general discussion be discouraged and that Dr. Routley be asked to give us information concerning what is being done in some of the Provinces in Canada to meet a situation similar to ours.

Chairman Lippincott: We will be glad, indeed to have Dr. Routley speak again.

Dr. T. C. Routley (Toronto): I did not want to take longer time this morning because I understood that some members of the Conference wanted to get away early. However, now that you have asked for some comments on the situation in Canada, I shall endeavor to respond.

I stated this morning that each Province in the country is autonomous in matters of health.

British Columbia. I have read the "Final Report of the Royal Commission on State Health Insurance in the Province of British Columbia." This Commission had representations made to it by the British Columbia Medical Association, by many organized groups and by individual lay people who desired to be heard, and the Commission makes some rather startling recommendations. Let me read you 1 or 2 of them: "That compulsory health insurance is proving to be an important and valuable factor in the improvement of health." **** "Also, because of the development of a system of illness prevention, which is the off-shoot of an organized health insurance scheme, it is valuable." **** It appears that the wish of the people of British Columbia, as submitted to us in evidence has been *overwhelmingly in favor of compulsory health insurance, and the maternity benefit scheme, for British Columbia.*" **** "No evidence of any weight, and scarcely any evidence of any kind, has been presented to us against the principle of compulsory health insurance; aside from those who object to any kind of medical treatment."

A system of compulsory health insurance and a maternity benefit scheme, are to be published at an early date in British Columbia with provision for: (a) general medical and surgical treatment; (b) hospitalization and maternity benefits. These are amplified, and copies of this report are available for any of you who are at all interested and I will be very happy to send them to you if you will give me your names and addresses.

The preferential medical organization there, 500 strong, is thoroughly organized, primarily for self-protection because these men found that something was going on that certainly demanded their careful scrutiny. The British Columbia Medical Association finally decided that it would support the contention for compulsory health insurance provided certain safeguards were incorporated. They were: (1) Free choice of patient by doctor and doctor by patient; (2) that the scheme be compulsory for all wage earners under a certain figure; (3) that there be no intervention of an Approved Society, or other third party to the scheme outside of the Government itself; and (4) that the doctors be paid for services rendered. These are the main points upon which the profession in that Province rested their

case. But, they are committed to the principle of compulsory health insurance when, as, and if, the Province is financially capable of introducing it.

Now, an interesting observation, I may add, is that—the actual figures seem to indicate that the cost of this service to the Province of British Columbia will be very much greater than those who promoted the scheme thought it would be—and it is very doubtful, in the minds of many, whether that Province will be able to establish this measure for a number of years to come, particularly bearing in mind the economic depression from which our country and the rest of the world are suffering.

In Alberta, the Government itself instituted an inquiry into the whole question of health and this document, called the "Report of the Inquiry into the Systems of State Medicine", was presented at the last session of the Legislature. That Province has between 500,000 or 600,000 inhabitants. You will be interested in the information which this Royal Commission Report in that Province has given to the people:

(1) Under state medicine there will only be as many physicians, druggists, nurses, etc., as are needed to do the work well.

(2) There will be no schools of medicine, cults or 'isms. The health service will reach every family in the nation. Every community will be a part of some health district served by all that medical science has to offer.

(3) They will make greater progress when organized.

(4) Research work will be part of the individual health service, their only object being —to discover new truths. There will be no money profit. New ideas will be tested and, if found of value, added to medical science. The inventor will be rewarded but there will be no swollen fortunes. Doctors will be paid liberal salaries. They will do their best, because good work will be the only way to secure advancement in the service. The economic side of their work will cause no trouble whatever. In ill health, they will be sure of the best attention and thus be relieved of that sort of anxiety. People will be taught to care for their bodies. Periodic health service will enable doctors to practice preventive medicine. There will be no loss of prestige by the physician. Preventive medicine will materially reduce the use of drugs.

Health activities will continue and the medical service will have full public confidence because the economic interests of the doctors and patients will be identical. Confidence will not only be restored but will reach a latitude previously unknown in the history of medicine. So much for that Province.

In Saskatchewan there are 301 municipalities; 75 of them now have *municipal* or *per diem* physicians. A municipal physician is a man who is hired by a given locality to look after all of the illness in that locality. If he is a whole-time man, that is his income. Their salaries vary from $3000 to $6000 *per annum.*

I saw an advertisement the other day, for some one to fill the position of municipal physician, and it called for a man well qualified to do minor surgery, tooth extraction and school inspection; he was to supply his own office and transportation, and was to receive $1800 a year; and I may say that they were not without applicants for that appointment.

Manitoba Province has approximately 600 doctors. Economic conditions are so bad out there that the doctors are demanding that something be done for them. They say they have simply reached the end of their tether and it appears that a conference will shortly be held between the governmental authorities and the doctors, looking to some arrangement whereby the doctors will be subsidized to carry on.

In Ontario, my own Province, an extraordinary thing happened in the month of September. To the best of my knowledge it is unique in my home Province. I hold in my hand a document called an "Order in Council". I cannot say whether our terminology is the same as yours, but it means a piece of legislation passed by the *cabinet* during a recess of Parliament, in contrast to legislation passed by the House in session. Authority is given to Cabinets, in our country, to enact urgent measures of legislation. We have some unemployment over in Canada, you know, and a lot of our people are in distress. There is nothing unusual about an *Order in Council* providing

for relief of the people but the extraordinary thing about this order is that, for the first time in our history, it says that relief of these unemployed persons shall include medical services and medical supplies—and the organized medical profession was not consulted prior to this announcement. It came as a great surprise to us, but there it is.

Clause II, which will, perhaps, become a classic with us, reads as follows: "Payment for medical services shall not exceed ½ of the standard medical charges existing in the municipality or locality." There is the Government deciding the matter. We were not consulted.

Now, as to how it is working out, of course it has the profession fairly excited. I was asked to make a survey of the situation. I endeavored to do so and have made a few comments on it. Medical services and supplies are to be paid for. In each organized municipality there is to be set up a Health Board under whose jurisdiction relief measures will be made. The societies are advised to wait upon these relief boards in order that the whole question of medical service can be discussed fairly and in respect to those to whom it may be administered. There are many people in the Province who question the right of the doctor to be paid out of relief moneys but it is certainly the wish and intent of the Government that the doctors be paid. The following arrangement has been suggested and is satisfactory to the majority of doctors with whom I conferred regarding the action the profession should take: "(1) That the individual be permitted to employ his family physician as he had done when self-supporting. (2) That the attending physician submit a bill in conformity with a plan adopted by the profession in his locality. (3) That the physician be prepared to accept 50% of the amount of his bill in respect to relief cases, thereby continuing to make a special contribution to the community welfare." In this manner the relationship between the physician and the patient remains inviolate and, indeed, this is the foundation stone of our issue in regard to the practice of medicine; and no arrangement should be tolerated which would tend to disrupt the relationship existing between doctor and patient.

Here let me interpolate some remarks made to me by people with whom I have talked. One profound thinker said: *"This may be the thin edge of the wedge. Many will say that out of necessity and adversity a reformation is taking place."* Another man: *"We really are experiencing a social revolution, bloodless it is true, but leading us somewhere"*. My own remarks: *"I am not prepared nor do I at present know any man who is prepared at this moment to outline to the profession exactly the course of action it should take. We are all puzzled."*

This problem is engaging the attention of thinkers in the profession and I venture to say that many groups of men like you, all over this country, are seriously thinking, as perhaps most of you never thought before. I have also the belief that the profession may be counted upon to see its way through any problem which confronts it but, in order to do so, *the medical profession* must become united, organized, and its members must coöperate with one another. *It is time for corporate thought and action based upon the results of serious thinking.* Our so-called, highly vaunted, *individualism has no part in this issue.* All of us admit the necessity, but I humbly submit to you that *we are apt to confuse the rights and privileges of individualism with the necessity for corporate thought and action*—now is the time for the *latter* and *not the former.*

Well, I go on, in this paper, to develop another phase, a phase which I call the *Near Relief Program.* I do not know just how this would measure up with you, here in the states of New Jersey, New York and Pennsylvania, but our study in Canada would lead us to conclude that while 1 family is on so-called *relief,* there are somewhere between 3 and 5 families in what we call the *near relief class.* They have a little money coming in, they are earning a few dollars and can still, on a reduced scale of living, pay their way and maintain their self respect, *but when sickness overtakes them they are defeated and have no money with which to pay for medical service.* What about this group? We still have them and for a long time we are going to have them; and, what is the profession going to do about it?

While on that subject, I made a few observations about that great class of people who are today rushed into the hospital, and are there treated gratuitously by the doctor for 2 reasons: (1) that the people want to go there to save medical fees; and (2) that the doctor thinks he would not be paid for that service outside anyway. One large hospital in Ontario shows a deficit this year above $300,000. Now, I offer for consideration, this suggestion. Let us take a maternity patient sent into the hospital at a cost to the state, for the mother and the baby, of from $35 to $75, and the doctor is not paid. May I ask, would it not be good business for the doctor to be paid for many of these cases and the mother kept at home in her normal environment, where her other children might possibly have the value of her partial attention, certainly after a period of 7 days, and the state be saved a considerable sum of money? "But", some one says, "we are over-hospitalized and the hospitals are clamoring for more patients." Nevertheless, they tell us that every charity case is a liability—not an asset. If that is true, the multiplication of these charity patients would certainly add to their hospital deficit, and I suggest that as the medical profession—not as Americans, nor as Canadians—we give serious thought to the solution of that problem, which is not only *medical* but, in my humble judgment, is *economic*.

The Province of Quebec, perhaps better known to people over here than some of the others, through its Medical Association, has made a report to the Royal Commission, that Province now being engaged in studying the question of Health Insurance. They call it *Social Insurance*. The organized medical profession in the Province of Quebec, according to its *ad interim* report, which is *not final,* seems to be *in favor of some form of health insurance;* though I am not quoting this Province in any statement I make here as being final. They hasten to add, however that they do not want the English panel system. We understand them to mean specifically, this much at least, that any scheme which is promulgated must not endanger the integrity and the honesty of the medical profession, and must permit free choice of patient by doctor and of doctor by patient.

I have given you this racy presentation of the problems in our respective Provinces in Canada primarily because I feel that it is well to learn what is going on in other places. I have learned a tremendous amount here today. I cannot tell you how grateful I am to have heard this discussion. No matter what we, in the medical profession, may think, there is a wave spreading over our countries, your country and my country, and it is spreading on—and on—and on, and people in all walks of life are thinking—how some better scheme than now exists for the payment of medical services can be devised. They will not cease in their efforts to bring this about until they are satisfied that the present scheme is all that can be given to them, or until the medical profession has promulgated some other scheme that satisfies them.

Sometimes I am accused by members of our profession—of talking too much about this subject. That may be true, but I humbly submit to you that a National Society Secretary who does not pass on to his people what he hears and sees and feels and believes, is remiss in the performance of his duty. I am not as yet advocating anything for our country because I am forced to admit that, like yourselves, I have as yet no solution to the problem, but those of us who are supposed to be leaders in the medical profession, in our various states and provinces, should plead with our colleagues that they examine the situation as it is, see the other fellow's point of view, and, if possible, reconcile those points of view.

I expect to discuss with our Federal Government, within a few days, the whole question of medical service. It has more or less been brought to a head by the economic situation, and I venture to say the same thing applies in this country. If this *depression* were not with us, there would be no worry. I would like to make this statement to you: I have never found in Canada any man or woman who quarreled with the ability of the medical profession to meet their needs. Indeed, I have found a number of lay people who have said this: You are in trouble because your science

has been too progressive and all-inclusive and comprehensive. In the old days, the family doctor could, with his marvelous intuition and ability, go into a home, see in his patient a case of typhoid fever or diphtheria, make the diagnosis, and with uncanny ability proceed to cure the patient. Today, we have x-rays, diathermy, blood tests, and various scientific procedures at command but—the man on the street says, "You know and have all this, but *how can we get the benefit of it?*" There is no question about the scientific progress of the profession, but there appears to be an inability to deliver our goods to the people at a market price they can pay. I think Dr. Leland said—that we should not confuse professional and business relations in regard to our patients. That is very true, but we cannot divorce the business from the professional side of medicine today unless we hand over all of the business side to some third party and that is the very thing that we are arguing against. Then, what is the answer? It has been said several times, and by repeating it I will close: The problem is ours and if we, as intelligent men and women, every one of us a University graduate, cannot settle this problem and find a solution, then, I humbly say to you, we ought to take our medicine. If we can only get every man of our organized forces, to come up on the firing line, including those men out on the cross-roads stations—God bless them!—if we could get that 50% of our physicians who shrug their shoulders and say, "Let George do it"—"It doesn't concern me" —to thinking about these problems, we would find a solution; and, if we do not, I hate to think what the final result may be. I am, however, still an optimist. I have full faith that the medical profession will find a solution. We cannot expect a standardized solution; probably do not want it. The solutions will vary according to the needs of our people and we will go on climbing greater heights until in the end I think we will enjoy just as high a pinnacle as we ever had.

Dr. J. B. Morrison (Newark): Mr. President, I think you are to be congratulated on today's program, and as this Tristate Conference, representing in a measure the States of Pennsylvania, New York and New Jersey, is the Eastern bulwark of organized medicine, I believe the deliberations of today, as they go out in print, will have a salutary effect upon the profession and upon the laity.

You may remember, Sir, that 2 years ago, in a talk at the Annual Meeting of the State Society, I predicted that we would be face-to-face with *state medicine* in these Eastern states within 5 years. Well, I believe that this "Report on the Costs of Medical Care" has done more than anything else which has happened during the past 15 years to bring state medicine distinctly "in the offing" in America. The Majority report offers some plans for consideration. One is the group practice plan. In our congested industrial communities this might work out, it might even be ideal, but what will it do in states like Texas with a widely scattered population? Group medicine there would be impossible. It must be done by individual physicians. The plan to carry on this relief around a hospital center, also, is not feasible. There are not 1/5 hospitals enough to give the service required outside of industrial areas. There would have to be hospitals all over the rural districts, not more than 15 to 25 miles apart, to meet the demands that would be made.

The medical profession today, with this thing sprung upon us so suddenly, is at the parting of the ways and, like the Hebrews in bondage in Egypt, we are looking for a leader and deliverer. Well, are there no longer any leaders in medical America?

At Chicago, they have advanced the Iowa plan. That and the Milwaukee plan are plans to treat the indigent sick at the expense of the municipalities. If you extend that further, to the white collar class, who will pay for it? The State; and *that is state medicine.*

I was given to understand at A. M. A. headquarters in Chicago, that they are looking for some obscure County Society Secretary or President to formulate a plan which will meet the conditions in his immediate locality, and hoping that such plan can be modified or changed so as to make it applicable to any locality in America, and ultimately to have it adopted all over the United States. If the

American Medical Association waits for such an event, it will wait a thousand years. The offices at Chicago, where we had hoped were gathered the best medical minds in this country, have been accused of being a "conservative bureaucracy", attempting to maintain the *status quo* through this perilous economic situation; instead of trying to solve the problem, and to effect a solution that would be the opening of a new era. They seem to be waiting for some Moses to be found among the bullrushes, who will find a solution to this profound economic problem, and they appear to be *shirking it themselves.*

In its first response to the Committee Report, I fear very much that the Headquarters Staff at Chicago has stepped off on the wrong foot. Seemingly, the one thing they have done is to arouse opposition and cause to be superimposed upon the old Committee another Committee, backed by unlimited financial resources and already offered the help of some public health groups, to carry on a fight against the medical profession. The first to speak from among those offended, tells us that if we want a fight we are going to get it. Now, it seems to me, that had the A. M. A. offered a little bit of coöperation, this bitterness would not have been engendered, and a bitterness once engendered is hard to eradicate.

Speaking in New York last Wednesday evening, Dr. John T. Hanks, a dentist, said in part: "The dental profession is about to be faced with a position politically sponsored to set up socialized dentistry, and, in order to anticipate the effect of such a move, the profession should set up its own plan; so that if it is to be put in operation only the highest ethical standards will govern it, under the control of the dental profession, and *not* under politicians." In line with that, let me say, in order to anticipate such a move as has been announced, the medical profession should set up its own plan and see that the very highest medical ethical standards shall govern the plan and members of our profession shall control it. Dr. Hanks *warned us that if a policy of complete opposition to compulsory insurance be adopted,* then, the dental and the medical professions would soon find themselves in the same position here that those professions held in Europe when, as a result of obstinate opposition, they were entirely ignored by the people and the politicians.

Now, that is exactly the position taken by me at the recent Conference of Secretaries and Editors held in Chicago in November; but I did not receive much in the way of support or encouragement. In this State wherever I go on my regular round of County Societies, since this report has been published, I am asked—"What is the American Medical Association doing? What is the Department of Medical Economics doing?" The only answer available as yet is—that the latest word from the American Medical Association indicates that its officials seem to expect a solution for our difficult problems to spring to life in some County Society.

It seems to me that we should make a study of *social medicine* in all its forms, and wherever it has been applied; and then develop a plan applicable to conditions. First—see the fact—Health Insurance is coming. In a few years it jumped from Europe across the Atlantic and now is in several Provinces of Canada. Say what you please about the people and conditions in Germany and France being different, these people in Canada are English-speaking stock, mainly, and they are in thought, in social living, social standards, medical economic problems, *just like ourselves;* the chief noticeable difference is that we are living under different flags. In the past 13 years laws to establish social medicine have been introduced in many of the state legislatures in America, and during this period of depression, with the impetus given by this sweep in the Northern countries, and with the effect of the propaganda proposed to be put forth by the new Committee, it will face us very soon. Now, if we can get together and work out a plan, it may be that we can conserve the rights and interests of our profession and, at the same time, satisfy those who are demanding some changes. Voluntary insurance is a good thing. We have had that in America for 56 years. It *is possible* that voluntary insurance *would eventually* lead to compulsory insurance, but that depends

upon the type of men with whom you are dealing. I believe that: if we make a thorough study of this subject, from every point of view; pick out the best features in the systems applied in countries abroad, and discard the worst features; see to it that medical rights and privileges and interests are maintained; see to it that the ethical standards are kept high; that the white collared class are given medical service at a cost which they can pay (they would not want paternalism); we need not hesitate to leave our case entirely in their hands.

Dr. Walter F. Donaldson (Pittsburgh): I am sorry that the last speaker indicted the medical profession for its lack of leadership or, at least, was not charitable enough to point out that most other professional and economic groups throughout the world, have during the past decade, been floundering about without satisfactory leadership. I do not believe that the medical profession is any more poorly represented than the banking groups, or the legislative groups, or any other important group. Furthermore, I cannot help but think that out of all of the consideration that is being given to this subject by the medical profession right now, they probably have some plans in the back of their minds, and that if we are to have state medicine or socialized medical practice, that will result in the adoption of a system in America, or some of its various states, which will be an improvement over any existing plan in any other country in the world today. I hold just as high hopes for the outcome of this problem as does Dr. Morrison, but I still have a little more optimistic point of view than he has and I feel like giving more credit to the thought that has been given to the matter by the representatives of the medical profession because I am sure that Dr. Morrison will admit, as I must admit, that at our State Society Conference held this week in Harrisburg we were just as much at a loss for a specific method of solving this problem as were the hundred men who gathered in Chicago 2 weeks before, and as has been confessed to us by Dr. Routley, who represents another group of American physicians.

Dr. Henry O. Reik (Atlantic City): Mr. President, there are many things I would like to have said in discussion of these subjects had we not spent so much time already, but there is evidently going to be plenty of opportunity to discuss this question for some time to come. I only want to say now, that I would like to tender a vote of thanks to Dr. Routley, Dr. Hartwell, and Dr. Leland for accepting our invitation to come here today to discuss these matters. I am sure you will all agree with me that I did not make any mistake when in London, in my estimate of the Secretary of the Canadian Medical Association.

Dr. Joseph S. Lawrence (Albany): May I express my appreciation of the program of today? The subject for discussion was, certainly, a very timely one.

We would like to extend to this Conference an earnest invitation to come to New York for its next session, sometime in January or February.

Dr. Reik moved the acceptance of this invitation, and his motion was adopted.

Dr. Lippincott: I want to thank you all for your attendance today, for the time you have taken out of your busy practices, and for the deep interest that has been evidenced.

Adjournment at 5.00 p. m.

Current Events

MINUTES OF THE WELFARE COMMITTEE MEETING

Trenton, N. J., Dec. 18, 1932

The first regular session of the Welfare Committee of the Medical Society of New Jersey for 1932-33 convened at the Hotel Stacy-Trent, Trenton, Sunday, December 18, and was called to order by the President of the State Medical Society, Dr. A. Haines Lippincott, at 2.10 p. m., the following members being recorded as present: Berkow, Bloom, A. H. Coleman, Conaway, Costello, Davis, Donohoe, Green, Hagerty, Haggerty, Haussling, Lippincott, Londrigan, McBride, McMahon, Morrison, Morrow, Mulford, North, Schauffler, Schlichter, Sewall, Sherman, Sommer, Tracy, and Ulmer. Excuses were received from Drs. Clayton, Lee and Larkey. The absentees were: Brown, J. G. Coleman, Dandois, Meigh and Towbin. Other members of the State Society present: Vice-President Quigley; and, as representatives of the State Board of Medical Examiners, Drs. McGuire and Kelley.

Telegram of excuse from Second Vice-President Ely. Drs. Steigerwald and Fischelis were present, as representatives of the State Dental Society and the State Pharmaceutical Association, upon invitation of the Executive Secretary, who was aware of their interest in matters to be discussed.

President Lippincott expressed his appreciation of the honor of having been elected to 3 successive annual terms of office as Chairman of the Welfare Committee; and then announced that he was prepared to receive nominations to fill that office for the ensuing year.

Dr. Green nominated Dr. Charles H. Schlichter, accompanying the nomination with a eulogy of the candidate, covering his interest in the work of the organization and his previous record as a worker in both the State and the Union County Societies.

Dr. Londrigan seconded the nomination and, as no other names were presented, Dr. Schlichter was elected unanimously.

Dr. Schlichter, having taken the chair, called for the report of the Executive Secretary, as the first order of business.

Dr. Reik read the following report: *(Needing the space for other purposes, this report is being carried over to the February Journal.—Ed.)*

Dr. Londrigan moved that the report be received and accepted.

Dr. Tracy, in seconding the motion, stated that he would like to amend it by saying that the report be *approved* and the Executive Secretary be *commended* for such an excellent report and for the services rendered during the period of time between the last Annual Meeting of the State Society and the present date.

The amendment having been accepted by Dr. Londrigan, the motion was unanimously adopted.

The Chairman called for consideration, *seriatum,* of the various items in the report.

Sections 1-6 were approved without debate, save that, in reference to Section 2—meeting legislation half-way—the action taken by the Executive Secretary was especially endorsed; and, with reference to Section 4, the Chairman was instructed to appoint a special committee to study the situation brought about by the recent report of the National Committee on the Costs of Medical Care and to report back to the Welfare Committee what action, if any, should be taken by this organization.

Section 7 was approved and the Secretary's suggestion, that a special sub-committee should be appointed to deal with the matter of War Veterans' legislation by Congress, was adopted and the Chairman instructed to appoint such a committee.

Section 8, dealing with local legislation, was then taken up as follows:

(a) *Dr. Londrigan* reported that he deemed it inadvisable to introduce at the next General Assembly any amendment to the Hospital Lien Law.

(b) The communication from Dr. Beasley, regarding the number of medical colleges being restricted, was laid upon the table.

(c) *Dr. Sommer* reported for the Osteopathic Conference Committee that a conference had been held and the subject of new legislation, concerning the practice of osteopathy in this state, had been discussed, but that as 2 representatives of the Osteopathic Society were in the hotel, he would request the Committee to invite them to sit in at this session while that subject was under consideration.

The Chairman, having asked the Committee to consider the suggestion made by Dr. Sommer, and the Welfare Committee having voted unanimously to invite them in, Drs. Colburn and English were escorted in, introduced to the members of the Welfare Committee, and invited to participate in the discussion.

Dr. Sommer then read his report of the Conference and the question was opened to general discussion, in which the following members participated: Sommer, Kelley, Londrigan, Costello, Schauffler, Schlichter, Mulford, Sherman, McGuire, Morrow, and the Executive Secretary.

At the conclusion of the discussion, Dr. Sommer suggested, and the Welfare Committee unanimously adopted his propositions, that the question should be referred back to his committee for further consideration and a report be presented at the next meeting of the Welfare Committee scheduled to be held on Sunday, January 8.

At this point several members of the Board of Trustees, which had been in session in another room, entered, and Dr. Nafey, Secretary of that Board, presented a message from the Board to the effect that the Trustees recommended the appointment of a special sub-committee to study the recent reports made public by the National Committee on Costs of Medical Care.

Chairman Schlichter announced that such action had already been taken.

Dr. Quigley amplified somewhat the message delivered by Dr. Nafey from the Trustees, explaining that the message covered also the desire to have the report referred to, particularly the recommendations contained in the Majority and Minority Reports, published in an early issue of the Journal.

The Executive Secretary announced that arrangements had already been made for the publication of the Reports, and also of the proceedings of the Tristate Medical Conference on December 10, where that matter was thoroughly discussed, in full in the January Journal; and, that a letter had been sent, during the previous week, to the Secretaries of County Societies requesting that they notify their members to be on the look-out for the January Journal and to give these matters prompt consideration.

Secretary Morrison referred to previous discussions of this matter and directed attention to his own prediction of 3 years ago, that "state medicine" would be a living issue in this state within 5 years; and added that he thought the so-called Majority Report had brought his prophecy to a conclusion 2 years earlier than he had expected.

The meeting then adjourned.

Henry O. Reik, M.D.,

Executive Secretary.

In Lighter Vein

Clear All Wires

"Put up your hands!" commanded the larger of 2 bandits who had stopped the coach. "We're goin' to rob the gents and kiss all the ladies."

"No", remonstrated the smaller one, gallantly. "We'll rob the gents all right, but we'll leave the ladies alone."

"Young man", snapped a female passenger of uncertain age, "mind your own business! Your friend's managing this hold-up!"—Legion Weekly.

Jersey Lightning and Then Some

"Did you ever taste moonshine whisky?"

"Certainly not", replied Uncle Bill Bottletop. "Anybody who can't swallow fast enough to keep from tastin' it has no business tryin' to drink it."—Washington Star.

Communications

OFFICIAL INFORMATION FROM HEALTH COMMISSIONER OF NEW YORK CITY

Shirley W. Wynne, M.D., Dr. P. H.,

"After January 1, 1933, the Department of Health will look to private physicians to make the medical examinations of all the 325,000 food-handlers in the city of New York. Such an examination is required by the Sanitary Code before a person can obtain a permit from the Department of Health to engage in any food-handling occupation, and this includes cooks, waiters, soda fountain employees, butchers, bakers, grocery clerks, etc. The object of the examination is, of course, to prevent the handling of food by those who suffer from some communicable disease.

The change in procedure does not, however, remove the supervision of the food-handler from the Department of Health; rather it is intensified. Heretofore, the applicant was examined, if he did not wish to go to a private physician, in the Special Clinics of the Department and the findings were checked up by the clerical staff. Now the applicant is to be *examined by his own doctor* who must fill in the application blank to give a complete history of the applicant's health as regards tuberculosis, venereal diseases, typhoid fever and skin diseases. The completed application form must be forwarded to the Division of Food Handlers, Department of Health, where it will be rechecked and the *Food-handler's Certificate* for the current year, bearing the seal of the Department of Health, is to be forwarded to the Examining Physician who, in turn, will hand it to the applicant."

Comment. The conviction that the State should not compete with private physicians in the practice of medicine, (italicized by the Editor) together with the precarious economic position now occupied by a large percentage of private physicians, has led Health Commissioner Wynne to re-organize the work so that hereafter all such examinations shall be done by private physicians.

"I feel that Municipal, State and Federal authorities should not enter into competition with private physicians in the practice of medicine. * * * * A person employed as a food-handler should be able to pay the small fee, once a year, charged by a private physician for this required examination. Furthermore, it is unfair to do this work at the expense of all the taxpayers, and I have, accordingly, taken this item out of the Department's budget for next year."

POST-GRADUATE COURSE IN MEDICINE

Under auspices of the Medical Society of New Jersey and Rutgers University

Recent Advances in Medicine and Surgery Prepared for Union County Medical Society

Time: 8.30 p. m. on Thursdays

Place: To be announced later. Probably in one of the Elizabeth Hospitals

Outline of Course

Lecture I—January 19

Recent Advances in Pneumonia Therapy

Dr. John A. Kolmer, Prof. of Medicine, Temple University Medical School, Philadelphia.

Lecture II—January 26

Cerebral Injuries

Dr. Temple Fay, Prof. of Neurologic Surgery, Temple University Medical School, Philadelphia

Lecture III—February 2

Recent Advances in Renal Diseases

Dr. William Goldring, Asst. Prof. of Clinical Medicine, New York University Medical School, New York

Lecture IV—February 9

Hypertension and Hypotension

Dr. Thomas McCrae, Prof. of Medicine, Jefferson Medical College, Philadelphia

Lecture V—February 16

Newer Thoughts in Surgery

Dr. W. Wayne Babcock, Prof. of Surgery, Temple University Medical School, Philadelphia

Lecture VI—February 23

Recent Advances in Diseases of the Liver

Dr. H. L. Bockus, Prof. of Gastroenterology, Graduate School of Medicine, University of Pennsylvania, Philadelphia

Post-Graduate Educational Committee Union County Medical Society:

Irving Lerman, Elizabeth, Chairman
Harry H. Bowles, Summit
Frederick W. Lathrop, Plainfield.

A POST-GRADUATE COURSE IN ORGANIC NEUROLOGY

(A letter from Mr. R. H. Light, of Rutgers University)

The Post-Graduate Course in Organic Neurology closed at Skillman Village last night and every one of the 26 doctors registered had attended 4 or more lectures of the course, so that they all received *Certificates of Attendance.* The enclosed list gives you the names and addresses of the men registered in the course. Dr. Renner told me that this was the best attended Post-Graduate Course they have had in his county.

The physicians attending were unusually well pleased with the course and liked the idea of having one man give all of the lectures—rather than have a number of lecturers giving different subjects.

Dr. Renner is going to have one of the men who

took the eourse write a short article for the Journal, telling how mueh the course meant to the men who took it. I thought that this would be extremely interesting to the readers of the Journal and might stimulate interest in other courses to be announced later among your members.

Some 3 or 4 County Soeieties have already selected their eourses and as soon as we know definitely whether we can secure the lecturers they want, I will pass their respective programs along to you for publication in the Journal.

The list of subscribing members follows:

Organic Neurology at Skillman Village, Somerset County

1. R. K. Adams, Skillman, Somerset Co. County.
2. Florence Child, 929 W. State St., Trenton, Mercer Co.
3. Isaac Cooper East, State Village, Skillman, Somerset Co.
4. Lancelot Ely, 128 W. High St., Somerville, Somerset Co.
5. F. L. Field, Far Hills, Somerset Co.
6. B. S. Fuhrman, Flemington, Hunterdon Co.
7. R. G. Gladen, Skillman, Somerset Co.
8. J. B. Gordon, New Jersey State Hospital, Marlboro.
9. R. F. Hegeman, 161 W. High St., Somerville, Somerset Co.
10. E. F. Hird, Bound Broow, Somerset Co.
11. A. W. Pigott, Skillman, Somerset Co.
12. A. R. Pittman, State Hospital, Trenton, Mercer Co.
13. Dan S. Renner, Skillman, Somerset Co.
14. Wm. G. Cchauffler, 21 Morven Pl., Princeton, Mercer Co.
15. Margaret Shirloek, Vineland State School, Cumberland Co.
16. T. M. Simon, Skillman, Somerset Co.
17. J. B. Spradley, New Jersey State Hospital, Trenton, Mercer Co.
18. A. L. Stillwell, 30 N. Bridge St., Somerville, Somerset Co.

Obituaries

Resolutions Adopted by the Passaic County Medical Society on the Death of Dr. Thomas A. Dingman

On November 9, 1932, one of the most beloved and esteemed of our members, Thomas Alva Dingman, died of aeute coronary disease, symptoms of which had been present for only a few weeks prior to his death.

Dr. Dingman was born at Spring Valley, New York, on February 13, 1879, the son of a capable country practitioner. There he received his early education in the country schools. Later, he entered Columbia University College of Physicians and Surgeons, to study medicine, and his internship of 3 years at Roosevelt Hospital, conpleted a very thorough preparation for his life work.

Dr. Dingman eame to Paterson in 1908, and became affiliated with the Barnert Memorial and St. Joseph's Hospitals. At the Barnert Hospital he was on the Staff of the Gyneeologic Department from the beginning of the institution until it was firmly established in its new home. At St. Joseph's ment, then as Associate of Dr. Kane in gynceology; Hospital, he entered first the Out-Patient Depart- and, finally, as head of his own Surgieal Service which he eondueted with a skill and thoroughness seldom fousd outside a teaehing hospital. Metieulous attention to pre-operative and post-operative eare, together with exeellent judgment and unusual operative skill, made him a Master Surgeon.

He was a man admired by all, within and without the medical profession, for his integrity, his fine principles and splendid charaeter. He had about



DR. THOMAS A. DINGMAN

him a Spartan sternness in adhering to his high ideals, but tempered by a surprising gentleness, thoughtfulness and tenderness when caring for his patients.

He was a former President of the Passaie County Medieal Society; a member of the State Medleal and the State Surgieal Soeieties; a member of the Ameriean Medieal Association and a Fellow of the Ameriean College of Surgeons.

At St. Joseph's Hospital he worked indefatlgably for the improvement of that institution. He was tireless in his willingness to teach the interne and nursing staffs. As President of the Staff, and as a member of the Building Committee he took a leading part in the rebuilding of that institution. He was always vitally interested in clinieal meetings, and in his frequent diseussions of surgical subjeets before this soeicty we enjoyed the benefit of his broad knowledge and training.

Thcrefore, Be It Resolved, that the Passaic County Medieal Soeiety takes this opportunity of expressing Its loss In the passing of one of Its leaders; and that a copy of this resolution be spread upon the minutes of this meeting; and

Be It Further Resolved, that a eopy of this resolution be sent to his family with an expression of our deepest sympathy.

(Signed) Frank Ash,
James Morrill.

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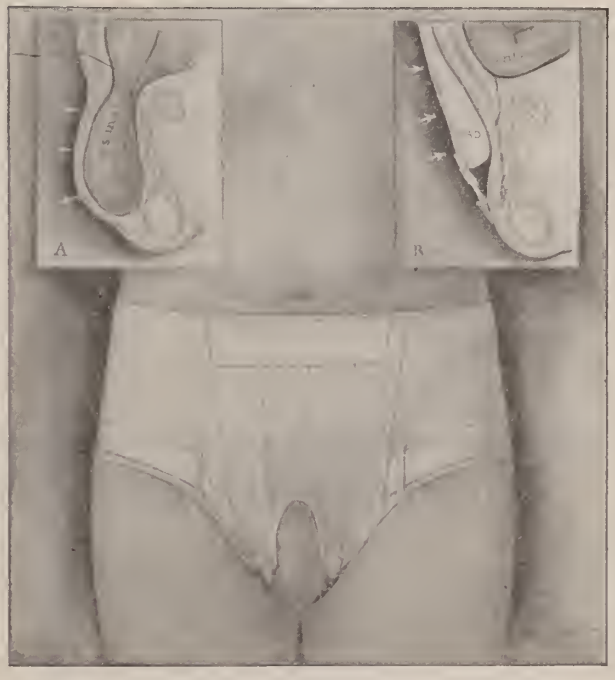
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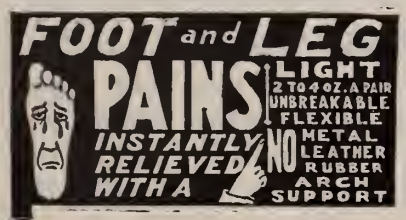
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HOSPITALS' REPORT AWAITS GOVERNOR

(New York Times, Dec. 5)

Howard S. Cullman, Chairman of Governor Roosevelt's committee to review medical and hospital prob'ems in connection with workmen's compensation insurance, and Dr. Adrian V. S. Lambert, Chairman of the medical sub-committee, have forwarded a letter to Governor Roosevelt, advising that a supplemental report dealing with medical abuses has been unanimously approved by the medical sub-committee and adopted by the Governor's committee.

The report itself, together with recommendations and a letter of transmittal, is awaiting Mr. Roosevelt's return to New York from his vacation in the South, when it will be filed and discussed with him by members of the medical sub-committee.

Governor Roosevelt has shown keen interest in this subject, both by the creation of this committee some 2 years ago and in his recent letter to the City Affairs Committee, in which he promised prompt and vigorous action against abuses upon receipt of a supplemental report which was then in preparation by his committee.

In its preliminary report made to the Governor on February 28 of this year, the committee condemned the system under which insurance companies carrying workmen's compensation were maintaining and operating private clinics for the treatment of injured workmen covered in their policies. One of the objections was that the system promoted the "lifting" of cases from responsible hospitals and the care of responsible physicians to clinics maintained by companies carrying the risks.

Other objections were that the clinic system had resulted in medical records concerning controversial cases emanating from doctors employed by the insurance companies; that the remoteness and inaccessibility of the clinics caused annoyance to patients, and that the system had given insurance companies a pretext for refusing to continue compensation payments unless the patient continued to attend such clinics.

The medical sub-committee consists of the following: Dr. Adrian V. S. Lambert, Chairman; Dr. George F. Chandler, New York State Medical Society; Dr. S. S. Goldwater, Hospital Consultant, former Health Commissioner of New York City; Dr. Edward A. King, St. Vincent's Hospital, New York City: Max Meyer, member of the Industrial Council; Dr. James Alexander Miller, Chairman, Public Health Committee of the Academy of Medicine; Dr. Frederick W. Parsons, Commissioner, State Department of Mental Hygiene; Dr. William H. Ross, President, New York State Medical Society.

JERSEY SURGEONS ELECT

(New York Times, Dec. 15)

Dr. Horace D. Bellis, of Trenton, was elected President of the Society of Surgeons of New Jersey, at the Annual Meeting of the organization in Elizabeth. About 60 surgeons from various parts of the state attended the meetings and visited clinics held in 3 hospitals.

Dr. Richard D. Freeman, of South Orange, was elected First Vice-President of the society, a position formerly held by Dr. Bellis. Dr. B. B. Ransom, Jr., of Maplewood, was made Second Vice-President; Dr. S. A. Cosgrove, of Jersey City, was reëlected Secretary, and Dr. George Blackburn, of Newark, was reëlected Treasurer.

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CLOSING SCHOOLS TO FIGHT SCARLET FEVER

(From the Literary Digest, Nov. 26, 1932)

A very poor plan, according to the Illinois health authorities. Sending the children home, suspending the teachers, and locking the schoolhouse doors in an attempt to suppress local epidemics is wasteful and unscientific, says The Illinois Health Messenger (Springfield):

"A less effective method of combating an epidemic of scarlet fever could scarcely be devised. (1) Less than 1/3 of the children of school age are susceptible to scarlet fever, so that a large majority of school children will not get it even if exposed. (2) Children in school can be reached and control measures applied much more easily and effectively than when schools are closed. (3) Closing of the schools loses whatever merit it might otherwise have, unless theaters, churches, and all other social gatherings, including sand-lot ball games, are likewise prohibited so far as children are concerned. (4) Unless the milk sold in the community is all pasteurized, a very prolific means of spreading scarlet fever is left open.

The most effective, economic, and scientifically sound way of managing the schools in the face of an epidemic of scarlet fever is based upon the following facts and observations:

(1) Susceptibility to scarlet fever can be determined by a test.

(2) The susceptible rate is higher among children of the primary than of the upper grades.

(3) Spread of scarlet fever can be controlled by vaccination and by quarantine.

(4) Pasteurization prevents milk from spreading scarlet fever."

MEDICAL EDUCATORS FOR CO-OPERATION

(Newark Evening News, Dec. 5)

New York—The Commission on Medical Education recommended "more coöperation and less competition" in medicine but opposed standardized medical service on a mass production basis.

Recently the Committee on the Costs of Medical Care advocated a semi-socialization of medicine.

The Commission was organized in 1925 by the Association of American Medical Colleges. Dr. A. Lawrence Lowell, resigned President of Harvard, is its Chairman.

Agreeing with the Committee on Medical Costs on the need of coöperation, the Commission came out flatly against standardized medical services on a mass production basis. The Commission pointed out this was impractical "because the unit of practice is the individual patient".

The report said the United States was overphysicianed and that too much emphasis was placed on specialization.

"Available data indicate that proper medical services can be provided on the basis of 1 active physician to 1000-1200 persons, depending on the size and type of the community", the report said. "The present number of physicians probably exceeds the need by at least 25,000, although the need of thoroughly qualified practitioners is and always will remain insufficient."

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

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WARREN.....	Raymond Wing, Blairstown.....	L. W. Hackett, Washington....	C. B. Smith, Washington

The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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RADIO AND MEDICINE MEN

(From the New York Medical Week, Nov. 19, 1932)

While most of the radio stations located in Greater New York maintain a notably high standard for medical publicity, every once in a while there is a lapse from grace. The lapse is pronounced in the case of WMCA and WPCH, who not once but regularly permit certain advertisement to go out which are opposed to truth and sound public health policy.

The Medicine Talk which comes from WMCA daily is a blatant example of uncontrolled medical advertising. The self-styled specialists who vaunt their skill in the treatment of varicose veins, hernia, hemorrhoids, etc., make their appeal to the ignorant and credulous, who do not understand that the advertising doctor must be paid not only for his services but for his elaborate and expensive publicity schemes.

The offender for whom WPCH is responsible is the Simplex Diathermy. Since even licensed physiotherapists may not give physical therapy unsupervised, obviously it is unsafe for laymen with no training at all to employ a powerful modality without guidance. In any case, the most ardent exponent of physical therapy would hardly pronounce diathermy a sure cure for rheumatism, high blood pressure and asthma.

It is platitudinous to assert that radio has become one of the most influential elements of standardization in American life. The level of standardization will be high or low according to the responsibility the broadcasting stations feel to their public. A station may be justified in giving the people what they want in the way of cheap music and witless jokes. There is no possible excuse for endangering the public health by misleading medical advertising.

ADMINISTRATION OF VITAMINS

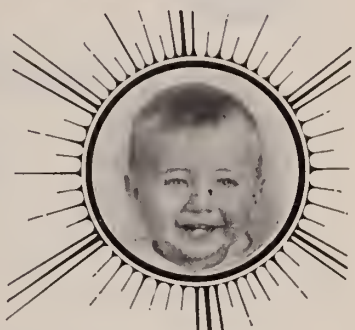
In standardizing McKesson's vitamin products, we have arrived by careful study at a given dosage level which we have demonstrated produces the best results, and we, therefore, hold that to administer vitamins in excess of the dosage level established does not produce beneficial effects in proportion to the quantity administered, but is only efficient in proportion to the amount absorbed.

Therefore, it avails us nothing and may even produce deleterious results, to administer mass doses of vitamins in the hope of effecting more rapid recovery that might ordinarily be expected.

(Note: See editorial in Journal of American Medical Association, September 24, 1932, on "Hypervitaminosis".)

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—because S.M.A. prevents Rickets and Spasmophilia.



SUMMER sun is an effective antirachitic agent but the physician cannot always depend on it, so he usually prescribes cod liver oil.

However, it is sometimes difficult to get the infant to accept cod liver oil, whereas it is easy to give it to him in the form of S. M. A. — a dependable automatic method of preventing rickets.

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NEW SERVICE GIVEN BY CANCER SOCIETY

(New York Times, Dec. 9)

The Board of Directors of the American Society for the Control of Cancer has embarked on a new service, that of a consulting board on problems in the cancer field, Dr. Clarence C. Little, Managing Director of the society, announced. The Board acted on the request of former Senator Joseph E. Ransdell, of Louisiana, Executive Director of the National Institute of Health, who had pointed out the need for such a consultative body.

Dr. Little said that the 30 members of the Board, including physicians, biologists, statisticians, financiers and others, would be qualified to act on such problems as, for example, whether some proposed form of cancer research would be likely to yield results. The Board agreed to act in such a capacity for the National Institute of Health, and it was hoped that the service could be extended to other organizations wishing to take advantage of it.

Dr. Little also announced that the Executive Committee had decided to have an "ambitious" exhibit at the Chicago World's Fair next year, including the use of electrical charts and devices and motion pictures, to brinb cancer statistics graphically before the public The exhibits will illustrate the nature, prevention and treatment of cancer. Dr. Arthur Estabrook will be in direct charge of the exhibit, which is under the auspices of a committee of which Dr. James Ewing of Memorial Hospital is Chairman.

The current bulletin of the society contains an article by Dr. Frederick L. Hoffman, member of its board, showing that the cancer death rate for 1931 was just a shade lower than for 1930. The article was reprinted from The Spectator, insurance periodical.

Dr. Hoffman commented that "the apparent decline possibly reflects the increasing improvement in cancer treatment though the progress in this direction is much less than had been anticipated". He said further that "the cancer death rate in this and other countries has possibly reached its maximum", but that "the situation as it is cannot be looked upon as otherwise than appalling".

The controversy over the possible effect of the inveterate smoking of cigarettes is revived in the current issue of The American Journal of Cancer.

The tar in cigarette smoke contains nicotine, ammonia and other irritants "which could account for 'cigarette cough', the chronic bronchitis of the cigarette smoker, the leukoplakia (smokers' tongue or smokers' patches) in heavy smokers, and the recorded increase of cancer of the lung", it is declared in a research report by Dr. William D. McNally, Assistant Clinical Professor of Medicine at Rush Medical College, Chicago.

"The temperature is not an important factor unless the cigarette is burned down to the last centimeter, when the hot smoke becomes more irritating", Dr. McNally continues. "Cigarettes should not be smoked too short, as the last 2 centimeters retain most of the tar and other products of incomplete combustion."

In another report on the subject by Dr. Emil Bogen and Russell Loomis, of Olive View, California, describing experiments on mice, the authors draw the conclusion that the chemical effect of the tar in tobacco smoke or distillate is not great enough to produce cancer.



APPROACH

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You are forced to compete with those who offer your patients free advice regarding medical treatment. You deliver Mrs. Blank's baby today, and tomorrow she will receive by mail samples of baby foods with complete directions how to use them. Indeed, some physician representing a commercial organization and knowing that the case is in your hands may address a personal letter to your patient offering his services free.

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Mead Johnson & Company have always believed that the feeding and care of babies and growing children is an individual problem that can best be controlled by the individual physician. For over 20 years and in dozens of ethical ways we have given practical effect to this creed. We hold

Continued on page XXVI

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Continued from page XXV

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MEDICAL COSTS

(New York Times, Dec. 1)

At whatever costs, both the majority and the minority reports of the Committee on Medical Costs agree, the general practitioner should be restored to his place—the central place—in medical practice, and the personal relations between patient and practitioner should be maintained. This is of first importance. It must be the *religio medici*. But there must be a group organization of some sort in order to bring such professional service within the reach of every man, woman and child. A society that does not recognize the obligation to make its skills in protecting and saving human life available for all has not reached or even approached its ideal.

How that is to be done there may be and is disagreement. The majority report looks in the direction of coördinating locally and regionally health and medical services and of distributing the costs over a period of time and over groups of families or individuals. This is, in fact, the direction in which medical provision is already moving, as the development of centres in many communities bears witness. But it must go further if competent medical attendance, now commanded by the well-to-do or the very poor, may also be within the reach of persons of moderate means. "Middle-rate" clinical and hospital provision would seem to be the outstanding need.

The motif of the majority report is medical care assured for all, with a reasonable compensation for the physician and nurse. It is estimated that all the needed care "of the kind customarily purchased individually" could be had (excluding capital charges) for from $20 to $30, or at most $40 per annum—from 40 to 80 cents per week—if only the services were coördinated and organized. It is difficult to think of any boon to mankind that would be more welcome to the millions of heads of families than the guarantee of competent medical attendance within the range of modest incomes. With this should be given not only the honor which from earliest civilization has been accorded the physician, but also a deserved tangible reward, for soon or late we all have need of him. Then, as Achilles said of Machaon, the Homeric doctor, "he is worth a host of us".

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OF THE

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PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 2 Orange, N. J., February, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

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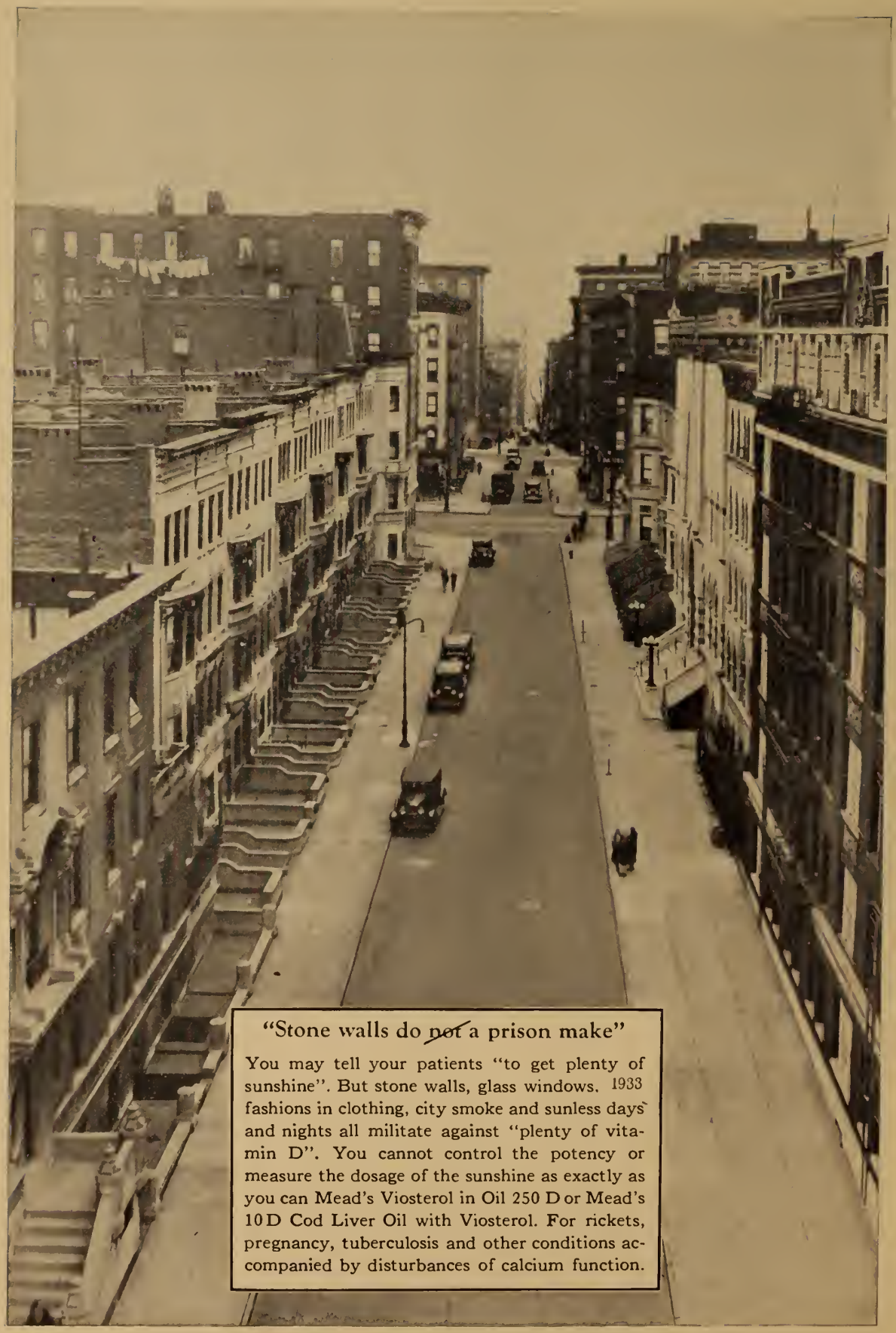
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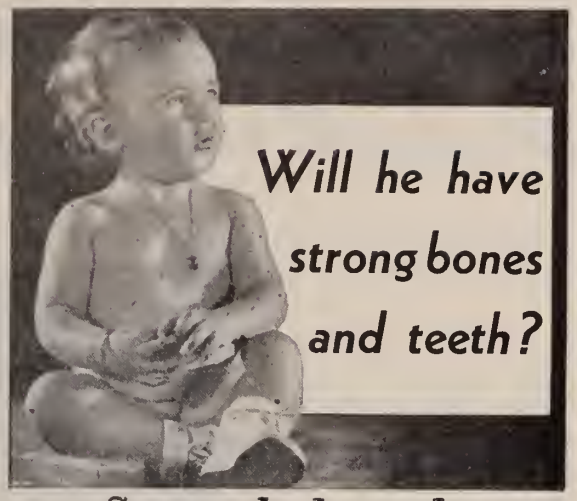
PLANS RESEARCH CENTRE

Merck Company to Open Laboratory Building at Rahway, N. J.

(New York Times.)

The new research laboratory of Merck & Co., Rahway, will be dedicated on March 1, George W. Merck, President, announced recently. The structure, started in 1932, will house in the south wing laboratories for pure research in biochemistry and pharmacology while the north wing will be used for applied research.

The central section will be used for offices of the directors of research, Dr. R. T. Major, Director of Pure Research, and Dr. W. H. Engels, Director of Applied Research. Dr. Joseph Rosin, technical director of the company and his staff will work on the second floor, which will also house a library.



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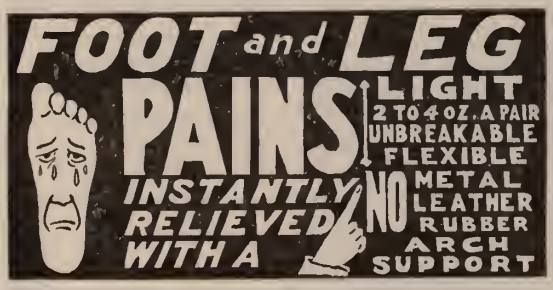


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CITY'S ACHES, PAINS TOLD BY ELLENSTEIN

(Newark Evening News, Jan. 12)

Problems confronting the Department of Public Works were discussed by Director Ellenstein at the weekly luncheon-meeting of the Newark Chapter, American Business Clubs, at Newark Athletic Club. He spoke on "Aches and Pains of a Big City" and related his experiences and reactions while in publice office.

'The city is confronted with problems which would not exist during a period of prosperity", Ellenstein said, "and the poor checks alloted to destitute families keep them just above the point of a starvation diet."

Dr. Ellenstein told how an increase in the city's population had brought over-crowded conditions to public institutions. He pointed out how hospitalization had increased to such an extent at the City Hospital that cots had to be placed in various parts of the institution. He also stated cases were sent to private institutions and the city pays $4 a bed in these cases.

He also cited the overcrowding of the city home and alms house, explaining the necessity for a new wing, which is being constructed at the latter institution. Dr. Ellenstein said he has added $5,000 to his department budget for cod-liver oil which will be dispensed by school nurses to children.

"As almost every one knows the valuable vitamins in cod-liver oil, I am sure the appropriation is not a foolish one", he said, "and a considerable amount of cod-liver oil can be purchased for this money."

In explaining an appropriation of $15,000 for free clinics, Ellenstein said all clinics should be removed from the Board of Health and brought to the vicinity of City Hospital, where x-ray facilities are available. Ellenstein said he had reduced his budget by $52,000 for the coming year, but said he found it necessary to appropriate $6,000 for cancer treatment.

Ellenstein asked for support in his "Winter Your Neighbor" campaign, which he inaugurated recently. He said $40 would carry a family of 5 over the remainder of the Winter and, with the supervision of the money by the giver, the destitute would gain much in food value.

Ellenstein said 21 per cent of the city's population was receiving aid from the city. About 10 per cent of those not receiving aid could assist in the campaign, he said, and thus afford a saving to the taxpayer.

NAMED ON GROUP COUNCIL

(New York Times)

Dr. A. C. Reed, Professor of Tropical Medicine and head of the Pacific Institute of Tropical Medicine of the University of California, has just been named to the Council of the American Society of Tropical Medicine for a period of 5 years.

From 1916 to 1927 Professor Reed was on the faculty of Stanford Medical School. From 1917 to 1921 he was Editor of the California State Journal of Medicine. During the war he was in charge of the medical service at the Mare Island Base Hospital. For 2 years, 1913-1915, he was Attending Physician at Yale Hospital in Changsha, China, and for 2 years previous to that he was Assistant Surgeon in the United States Public Health Service, stationed at Ellis Island. His medical degree was obtained at Bellevue Hospital Medical College, and his bachelor degree from Pomona College. He is consultant in medicine or tropical medicine for a number of hospitals.

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I'm going to bring him down to your office Wednesday as you suggested. That S.M.A. folder you gave me says even a breast fed baby should be under the supervision of a physician and I think myself that it's better to *keep* the baby well than to wait until trouble starts.

We certainly want to thank you for bringing our baby along so well, Doctor. It increases our confidence in you as our family physician. Tom has already "said it with dollars", but I wanted to thank you personally, too.

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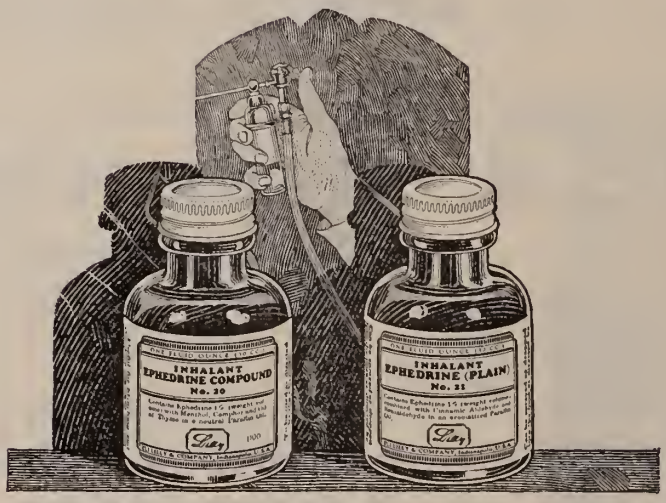
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Journal of The Medical Society of New Jersey

Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Vol. XXX., No. 2 ORANGE, N. J., FEBRUARY, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

PLASTIC SURGERY OF THE NOSE

Lyndon A. Peer, M.D.,

Newark, N. J.

The importance of the nose as an olfactory and respiratory organ has long been recognized, but little attention is given to the cosmetic aspects by the profession, and yet there are few more hideous deformities than destruction of the external nose. Those afflicted by this condition are apt to be avoided socially and excluded from all useful occupations save the most menial forms. Lesser degrees of nasal deformity, occurring more frequently, exert the same influence on the individual, moderated, perhaps, by the amount of disfigurement and his psychic characteristics. Such deformities are socially important because the patient usually develops an inferiority complex which induces him to avoid other people. I have a patient who remained in the care of a Christian Science healer while the whole lower portion of his nose slowly ulcerated away. He finally consulted a physician, who began antisyphilitic treatment and the remainder of the nose was saved. At the present time, he goes to work with a patch over his nose and is in constant fear of dismissal. There is also a type of individual, usually neurotic or egocentric, who comes to the plastic surgeon for correction of a very minor or fancied deformity. These patients should be discouraged, as they will be dissatisfied with their appearance regardless of operative results.

In this paper I shall describe the correction of common types of nasal deformity. The procedures vary according to the disfigurement but certain definite rules may be formulated which apply in all cases.

(1) Explain to the patient just how much improvement he may expect, keeping in mind the results which you may previously have obtained with similar conditions.

(2) Make a careful plan of procedure before operation.

(3) Never operate in the presence of furuncles on the nose or upper lip.

(4) Do not perform a plastic operation where such things as infected teeth, sinus infection, infected tonsils, or untreated syphilis exist.

(5) Always examine the septum in any deformity which affects the alignment of the nose. A deflected septum will prevent free movement of the re-fractured bony ridge and hence should first be removed.

(6) Do not combine a submucous resection and an extensive rhinoplasty at the same operation. Organisms within the nose and in the sebaceous glands always contaminate the incision, and wide undermining provides an excellent opportunity for their development. A two-stage operation is recommended.

Plastic surgery of the external nose may be divided into 2 main classes: (1) correction of nasal deformities in which all the normal elements of the nose are present but not in their proper position; (2) correction of nasal deformities in which some portion of the nose is absent. The first type of deformity is usually corrected by rearranging the bone and

cartilage of the nose without utilizing tissue from other parts of the body. In the second type the missing parts must be replaced. The surgical repair of each type of deformity will be described separately.

The acute fracture. The fracture may be diagnosed by distortion of the bony bridge or by eliciting crepitus on manipulation of the bones. A history of previous fracture and a description of the nose before the accident should be sought, in order to determine the extent of the injury. A radiograph is indicated, to rule out fractured skull and to establish the presence of a nasal fracture for medico-legal purposes. A simple fracture of the bony bridge not causing deformity externally and not occluding the intranasal space, should be left alone surgically. This type of case is treated by constant application of 5% magnesium sulphate compresses applied over the nose until all swelling has subsided. Hematoma of the septum must be incised and evacuated. A depressed fracture of one side of the bony bridge is repaired immediately by elevating the depressed fragment and holding it in position by a gauze pack within the nose. Fractures first seen 5 days or more following the accident may not be treated in this way as fibrous tissue has already formed about the fracture and will pull the fragment down when support is removed. Such conditions are repaired by fracturing the sound side and narrowing the bony bridge. Compound and impacted fractures are treated by manipulating the bones into proper position and applying dental stent over the bridge for immobilization. When a fractured nose is present with a fracture of the skull or severe head trauma, treatment depends on the patient's condition. No procedure which impairs recovery is justifiable.



1-A. Depressed tip.



1-B. Result 2 months after operation. The patient has improvement in breathing in addition to the cosmetic result.

Depressed tip. There are 2 kinds of depressed tip: (1) cases with a definite absence of sufficient tissue between the nasal tip and upper lip (a short columella); (2) cases which have sufficient tissue between the nasal tip and upper lip (a normal columella).

The first group is repaired by utilizing tissue from the upper lip to lengthen the columella, thus releasing the short band of tissue which holds the tip down. Further procedure

is the same as with class 2, which has sufficient tissue between the tip and upper lip. A triangle of cartilage and skin is excised just behind the columella with its base along the dorsum of the nose and the tissue sutured. This pulls the tip upward for a distance approximating the width of triangular tissue excised. The lower lateral cartilages supporting the ala will often buckle when the tip is elevated. These should be removed, leaving a small portion about the free margins for support. In addition to the above procedures, I completely undermine the nasal skin and slide it upward, holding it in firm contact with the deeper structure. In a few days the skin will become adherent and retain the tip in its new position.



2-A. Moderate saddle nose with hump over bony bridge.



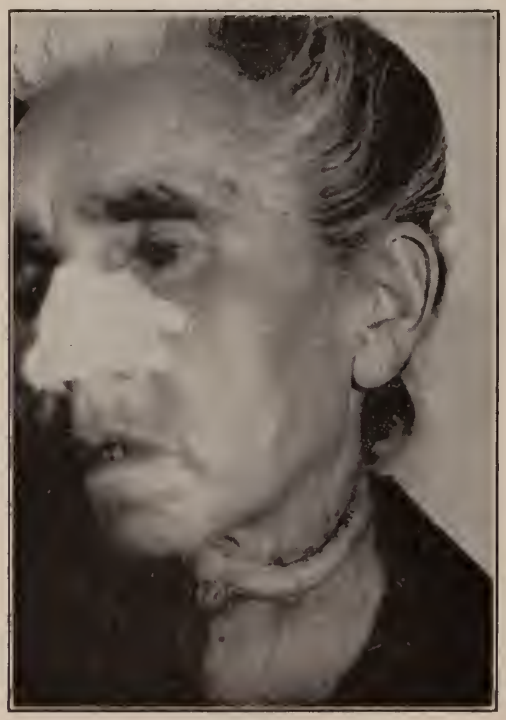
2-B. Result after repairing saddle with lower lateral cartilage and removing bony hump.

Hump nose. The hump may affect the bony bridge, the septal cartilage, or both. An incision is made inside one ala and the skin freed by scissor dissection from the deeper structure. The periosteum is then incised and peeled down on either side from the bony bridge. The hump is removed by a chisel, and the rough edges smoothed down with a rasp. When removal of a hump leaves a groove along the dorsum of the nose it is necessary to fracture the bony bridge on both sides and press the bone together. A thin layer of dental stent, moulded over the nose and held in place by adhesive, will control the hemorrhage. This can be removed in 48 hours and magnesium sulphate compresses applied over the nose to reduce the swelling.

Lateral displacement of the bony bridge. Ascertain first that there is not a deviation of the upper portion of the septal cartilage. This, if present, will serve as a bumper to prevent approximation of the bones after they have been fractured. When such a deviated septum occurs, a high submucous resection must be performed to remove the obstacle. Incisions are made in each ala and the skin separated from the deeper structures along the sides of the bony bridge. Make the fracture with a chisel through the nasal process of the superior maxilla. Be careful to sever the bridge close to its attachment with the maxilla or an unsightly ridge beside the nose will result. If the fracture is carried too far up and laterally, injury will occur to the lacrimal sac, resulting in a discharging fistula. After separating both

sides of the bony bridge the fractured bones are rearranged in correct position and dental stent applied for 48 hours. The bony bridge may also be fractured with a fine chisel through the skin on the outside of the nose. This method, devised by Mosher and used almost entirely by Kazanjian, is quickly executed and causes very little bleeding.

Lateral displacement of the lower nose. The displacement is due to distortion of the septal cartilage, which carries the lower nose to one side. Obviously, the twisted cartilage must be removed before the nose can be properly aligned. This often requires complete removal of the septal cartilage, including the portion along the dorsum which is left for support in the conventional submucous resection. After complete removal of the septal cartilage only a moderate saddle occurs and this is repaired at a later operation. The upper and lower lateral cartilages with their tough fibrous support form a bridge between the lower margins of the nasal bones and the tip, and this bridge, unaided by the cartilaginous septum, is sufficient to hold up the nose aside from the moderate sinking already described.



3-A. Tube flap formed on neck to replace partial loss of nasal tip.

Saddle nose. This group comprises the shallow forms of saddle nose and is divided into 2 classifications.

(1) Cases with all of the nasal elements present but not in their normal position. Such deformities are due to trauma and improper development. A blow on the nose, causing a fracture dislocation of the septal cartilage and a depressed fracture of the bony bridge, involves no actual loss of structure but still gives rise to a saddle. The normal elements of the nose in this case are still present but not in their proper position.



3-B. One end of tube severed from neck and attached to cheek nearer the nose. This permits the attachment of the outlined area of skin (a) to the nose without tension on the pedicle. The tube flap has been migrated up into proper position.

(2) Cases with destruction of the septal cartilage. This type of moderate saddle nose results from septal abscess, lues involving only the septum, and extensive submucous resection. There is an actual loss of structure in these cases but the depression is not so extensive as one is led to believe. A caving-in occurs on the dorsum of the nose because of the absence of septal support at a point above the

fibrous tissue connections of the upper and lower lateral cartilages. This caving-in, or saddle, is never very deep, since it is limited by the support of the upper and lower cartilages with their fibrous tissue connections. Both types are repaired by utilizing tissues within the nose. The bony bridge, when depressed, is to be re-fractured and elevated. A depression over the septal cartilage is filled with strips of lower lateral cartilage placed one on top of the other and sutured together. This graft may be reinforced by cartilage from the ear when it does not possess sufficient bulk to fill the cavity. The graft is inserted through an alar incision or through the columella.



4-A. Severe sulphuric acid burn of left ala, root of nose and forehead. The denuded area on the forehead is covered with a split graft taken from the leg but the ala and root of the nose are best repaired by a tube flap.



4-B. A tube flap was formed on the left arm because the neck skin had considerable scarring. After 2 weeks, 1 end of the tube is severed from the left arm and attached to replace scar tissue in left ala with the arm elevated and bandaged to the head.

Deep saddle nose. This results from destruction of the elements supporting the nose. Absence of the cartilaginous septum will not cause a deep saddle unless associated with extensive ulceration of mucous membrane lining the nose or injury to the bony bridge. If the bony structure is flattened or displaced, it must be re-fractured and set in proper position, and after a period of 3 weeks rib cartilage is inserted through the columella to fill the saddle. It is most important to shape the graft so that it just fills the depression and accurately fits the contours of the structures on which it rests. A straight piece of cartilage resting only on the nasal root and tip will tend to become distorted. All periosteum should be removed from the cartilage before insertion, as contracture of the periosteum will cause the graft to bend. A cartilage buttress placed in the columella will hold the graft in position and prevent sagging of the tip. Sometimes the upper end of the graft twists to one side after it has been in the nose a few months. This is easily corrected by making a small incision at the root of the nose and re-shaping the graft.

Deep saddle nose with loss of mucous membrane lining and scar tissue replacement. This is the typical syphilitic saddle nose. In addi-

tion to destruction of the septum and bony bridge the lower nose is pulled down by fibrous tissue contracture resulting from ulcerations within the nose. The first step is to free the adhesions, remove all scar tissue, and prevent recurrence by providing a skin covering over the denuded area inside the nose. Various types of free skin grafts are advocated but none of these has been successful in my hands. The Thiersch graft is too thin, and full-thickness grafts do not take well in a syphilitic nose. I line the nose with a tube flap formed on the arm. After the tube is 2 weeks old, the arm is elevated and attached to the head. One end of the tube is severed and inserted over the denuded nasal surface inside the nose. In this position the skin receives its nourishment through the pedicle attached to the arm until a proper vascular supply is established in the nose. One week later, the tube is severed close to the nostril and the arm lowered. This method, which was devised by Straatsma, is the most satisfactory way to line a syphilitic nose. After the graft is firmly established, rib cartilage may be inserted to elevate the dorsum and tip of the nose.



4-C. After 1 week the end of the tube attached to the arm is severed and sutured to replace scar tissue between the brows.



4-D. After 12 days the excess of skin is cut away and the tube skin sutured to the surrounding skin margins. An excess of skin is left in the new ala to allow for subsequent contracture.

Partial loss of the external tissue of the nose. A complete discussion of these conditions would fill several volumes and only the important features will be stressed in this article. The deformity usually results from automobile accidents in which a portion of the nose is sliced off by glass from the windshield. Syphilis and cancer also frequently cause destruction of the external nasal structure. Full-thickness pedicle grafts are used in the repair. These are of 2 types: the forehead flap and the tube flap.

Forehead flap. The forehead graft is cut with the pedicle attached in the region of the supra-orbital vessels, and sutured to cover the nasal defect. When a lining is required for the inside of the nose, the under surface of the skin to be transplanted is covered by a Thiersch graft. This method always leaves some scarring but the skin is an excellent match in color and texture with the nasal skin.

Tube flap. In my opinion the tube flap is the best means of repairing a partial loss of the external nose. Tube flaps are formed on the neck or arm and allowed to remain in position for 2 weeks. One end is then partially detached or "delayed" and a week later completely severed. The arm is then elevated and bandaged to the head so that the severed end of the tube can be fastened to the nose without undue tension. When the skin has been in its new location for a week the tube is cut and the arm gently lowered to the side. The portion covering the nasal defect is then



4-E. Front view showing new left ala and tube skin graft between brows.



4-F. Side view, left side, showing new ala.

shaped and sutured to the surrounding skin margins. The neck flap is not used with male patients because of its hair-bearing quality but it is an excellent means of repair in women. In general, I believe that the tube flap formed on the arm is best suited to replace partial loss of the nose. In women the neck may be used, but the forehead is not desirable because of scarring.

Summary

(1) The social importance of nasal deformity is discussed.

(2) Definite rules of procedure are given, applying to all plastic operations on the nose.

(3) The correction of common types of nasal deformity is described.

DISCUSSION

Dr. Henry C. Barkhorn (Newark): It is peculiarly apt that I should start the discussion on this subject because I admire it tremendously, but do not do it. Greater advances have been made along this line since the War than in any other. We must all stand back in admiration for exhibitions of major surgery such as this. It is no longer beauty surgery; it is major surgery which rehabilitates the ordinary man and woman. Worse luck, they are all *ordinary* men and women, which is not very remunerative! It is a tedious, long, difficult, repeated job for the gilt-edged poor; the rich do not have this sort of thing happen to them. It is a field all to itself. It is remarkable how comfortable Dr. Peer keeps his patients by fussing with them, by having the nurses give them very careful and detailed attention. I think it is a splendid piece of work.

Dr. Charles W. Buvinger: I would like to ask Dr. Peer about the tube flap. He said the tube flap was an idea of Dr. Straatsma; I mean the way it was used. That may be true, but if he will look into the literature he will find that the French were using this tube flap very extensively during the War; and while I saw Dr. Straatsma, and admire his work, it is a question just what he meant; whether this application of the tube flap was Dr. Straatsma's idea, or whether he meant to convey that it was entirely a new idea.

Dr. Peer: Answering Dr. Buvinger's question first, the tube flap, in principle, is an old surgical procedure. Pedicle skin flaps were used by the Hindus 2000 years ago to repair mutilated noses. The skin flaps were cut from the forehead and swung down to replace a loss of nasal substance. The procedure of using forehead flaps, as described in my paper, is the same method devised by the Hindus with the addition of a skin lining for the under surface of the flap. Tagliacozzi, an Italian, in 1597 described a method of nasal repair by making a pedicle skin flap on the arm, elevating the arm, and attaching the skin flap to the nose. Gillies is credited with devising the tube flap, but the tube flap is merely a pedicle skin flap with the skin edges of the pedicle sutured together, so as to leave no raw surfaces exposed.

To come to Dr. Buvinger's specific question, I meant that the method of utilizing the tube flap for lining of the inside of a syphilitic nose was a procedure devised by Dr. Straatsma and developed by both of us at the Newark Eye and Ear Infirmary.

I wish to thank Dr. Barkhorn for his very nice comments. I feel that he emphasized an important point when he said that the real reconstructive plastic surgical operations require a great deal of patience. A careful adherence to the general rules given at the beginning of the paper will avoid many later difficulties.

DIATHERMY IN TREATMENT OF CHRONIC DEAFNESS; A NEW TECHNIC

D. M. Yazujian, M.D., F.A.C.S.,
Trenton, N. J.

Advanced chronic catarrhal deafness is one of the most baffling diseases met by the otologist. In the past, our attitude toward patients suffering from this deafness has been to put them through various tests, make the diagnosis, render an unfavorable prognosis, and let them drift to the quack; or, at best, advise them to learn lip-reading or use mechanical devices to amplify sounds. I am referring to those patients in whom the low tones are obliterated, high tones shortened, and with bone conduction coming near to or surpassing air conduction. The chief pathologic processes we have to fight against in these cases are hypertrophy and, later, fibrosis of the tympanic structures.

When physicians began to use diathermy in various fields, the otologist soon became alert to its possibilities, and such men as Hurd, Dillinger, Stewart and Warring did pioneer work in surgical diathermy. Heat has a relaxing effect on spastic conditions. Some years ago, the writer began his experimentation of applying heat to the ears by diathermy, especially for the cure of chronic deafness, and this paper is a brief account of his investigation and results, and he intends to amplify it by other reports shortly regarding both deafness and chronic purulent middle ear disease. He, like others at first, applied diathermy to the ears by the *indirect method,* that is, by connecting the active pole of the diathermy outlet to the patient by having him sit on a charged pad, and "drawing" the current with his fingers; later, by the *direct method,* that is, instead of drawing it with the fingers, putting in ear-electrodes connected to the active pole of the outlet. But, by neither of these methods was the object of diathermy (heat *through* tissues) achieved; the current did not pass through the middle ear as was intended. High frequency current is converted into heat where it meets resistance, and in the way it was being used it met such resistance at the meatus—far from where it was needed. We know that when 2 electrodes of equal size and surface are connected, one to the active and the other to the inactive binding-post of the diathermy outlet, and then are applied to the opposite surfaces of any tissue, the field of current action will be the tissue between those electrodes.

I thought of utilizing this principle in the ears, by placing electrodes, connected with the indifferent post of the medical diathermy outlet, one in each nasal passage, going over its floor, passing under the eustachian opening and resting in the postero-lateral niche of the epipharynx; and by connecting 2 other electrodes to the active post of the medical diathermy, and introducing 1 in each ear to a depth of 2/3 of the external meatus; the middle ears being then directly in the current's pathway.

In order to effectively apply and regulate the current I had to devise the following:

(1) Nose and ear electrodes; a pair of each. The nose electrodes are well insulated where they touch the nasal floor, but both ends are left bare. The ends that are inserted into the ears and nose are triangular so that cotton can be wrapped around them; and the ones that are intended for the cords are shaped so as to fit into the cord ends.

(2) The *head-piece* consists of a head band and 2 electrode holders; the latter being 2 metal arches, each with an eccentrically placed insulated hole, and marked "R" or "L" for the right or left ear. The advantages of this head-piece over others are: the operator can see where and how far into the meatus the electrodes are going; they are very light in weight and do not touch but arch over the ear, with the contact arms resting in front of and behind the ears; they are easily adjustable and can readily be moved in any direction necessary to proper alignment.

(3) *The cords* are made of very light material so as not to drag down the electrodes when attached. The ear cords are of different colors so that the operator can tell which ear is connected to which binding post of the current-controller, and a third cord is spliced into one for connection, one arm going with the 2 nasal electrodes.

(4) *Duplex current controller.* The controller gets its current from the *active* post of the diathermy outlet and feeds it to the 2 reducers through separate controls. As each reducer is to be connected to one of the ear electrodes, the current going to each ear can be regulated separately.

Technic of Operation

(1) The patient should be seated in a comfortable chair placed either to right or left of the electric cabinet, and should be assured that there will be no pain, shock or any discomfort during the treatment.

(2) Cocaine (8% sol.) should be applied once to the nasal mucous membrane as far as the posterior choana; pharyngeal wall should not be anesthetized.

(3) While the cocaine is taking effect, cotton should be wound to the triangular ends of the nose and ear electrodes in a *cylindrical,* not conical or spindle-like, way; and care must be taken that the electrode *points* are well covered. Cotton thus wound should give the electrode ends a thickness about 25% more than their insulation and, so far as possible, equal in all 4 electrodes.

(4) The cotton-covered electrode tips are then dipped in normal salt solution and the excess of the fluid is gently squeezed out, care being taken not to squeeze them too dry.

(5) The ear electrodes are placed in their holders and the operator, stretching apart the 2 ends of the head band which holds the ear pieces, introduces a tip into each meatus, and moves the holders in any direction required to bring the electrodes in alignment with the meatal passages horizontally. The latter are, then, gently pushed in toward the drums 2/3 of the depth of the canals, but *under no circumstances allowed to touch the drum.*

(6) Next, the nasal electrodes are introduced in contact with the floor of the nose and until the posterior pharyngeal wall is reached.

(7) Over the outside ends of the aural and nasal electrodes, are slipped the tubal ends of their respective cords.

(8) The dials on the current reducer are set at maximum and then 1 (only) of the gaps of the diathermy machine is opened slowly until the spark is just visible. If the machine is provided with a sensitive meter it should register not more than 40 m.a. If not provided with a delicate meter, you can procure a special pre-adjustment unit which, when inserted in the patient's circuit, will furnish a setting easily read on the standard meters used. In a few seconds the patient will begin to feel heat in the ears.

(9) It should be explained to the patient that *gentle heat* is desired and if the heat becomes intense he must immediately tell the operator. If one ear feels too hot the reducer on that side should be retarded; if both ears get too hot, the *gap* should be narrowed. While

the current required is 30-60 m.a., meters should not be depended on because very few are sensitive enough to record such a small current correctly; even if they were, the tissue resistance to current is not the same in all patients, and there may be slight variations in the thickness of cotton tips.

The operator himself should attend to this technic, because technicians or nurses not understanding the anatomy of the nose, throat and ear may do much harm in applying electrodes. After all technical points have been attended to by the physician, the technician or nurse may be trusted with control of the current, which is liable to show variations during the 15-20 minutes of treatment, and see to it that the patient is getting at all times enough heat to feel comfortably warm in the ears but no more.

(10) With treatment ended, the current is turned off at the cabinet main switch; the ear electrodes are pulled out and their cords disconnected; the head piece, with electrodes still in, is removed; the nose electrode cords are disconnected and the electrodes removed, to be sterilized by wiping with alcohol.

(11) Immediately following diathermy treatment, pneumatic massage may be given. For this purpose, the writer uses a rubber cup which takes in the whole ear and has a hole which can be closed and opened with the index finger to increase or decrease negative pressure. Massage is followed by alkaline and oily sprays, and appropriate applications to the posterior pharynx; and the treatment is completed by catheterization of the eustachian tubes or by politzerization, according to indications.

Analysis of 5 case histories, 4 of them cases of advanced catarrhal deafness and 1 a moderate nerve deafness, perhaps as sequel of erysipelas, showed that all obtained satisfactory hearing resulting from this treatment.

Besides these advanced cases, I have used diathermy also in ordinary chronic conditions, combining it with the routine treatment, and believe that it expedites the recovery of hearing.

EXOPHTHALMOS: ITS RELATION TO NEOPLASM AND NASAL ACCESSORY SINUS DISEASE

Willard G. Mengel, M.D.,
Camden, N. J.

Exophthalmos occurs in association with a large number of diseased conditions, and its appearance is indicative of more or less serious disturbance of health, either closely or remotely related to the orbit. One of the more frequent factors in its production is orbital cellulitis secondary to a nasal accessory sinus disease. This condition is oftentimes difficult to differentiate from the early stages of orbital neoplasm, a condition extremely grave, so far as the life of the patient is concerned, and consequently very important for early diagnosis.

Among the systemic diseases producing exophthalmos, goiter is most frequent. Infantile scurvy is not an infrequent cause in children less than 2 years old (as reported by Dunnington), and rarely, it is seen in diabetes.

Orbital cellulitis and orbital phlegmon are frequent factors in the production of exophthalmos. These conditions may follow injuries to the orbit, transmission of inflammation from neighboring structures, such as the nasal accessory cavities; erysipelas; or it may follow metastasis in pyemia, scarlet fever, smallpox, purulent meningitis, or influenza. Cavernous sinus thrombosis and tumors of the orbit are not rarely associated with proptosis.

The nasal accessory sinuses, because of their proximity to the orbit, are directly responsible for a large percentage of cases of proptosis; the ethmoid sinuses probably more frequently than the others. In children with acute "head colds" or acute ethmoid sinus infections, proptosis is not rare, and it calls for energetic treatment.

Some interesting case histories of exophthalmos are herewith recorded:

Case 1. A. Y., a white girl, 15 years of age, was admitted to Wills Eye Hospital on March 16, 1931, complaining of swollen left eye-lid and prominence of her left eye. About 4 weeks

previously the left upper lid became swollen and, 1 week later, prominence of that eye and double vision were noticed. Redness of the eye, increasing protrusion and double vision, became progressively more marked.

Examination showed proptosis of her left eyeball down and outward. Conjunctival vessels were engorged and a small subconjunctival hemorrhage was noted on temporal side. Upper lid was swollen, and showed increased vascularity. Ocular movements were limited in all directions except downward. Cornea, anterior chamber and pupil were normal. Vision in both eyes 5/6. Ophthalmoscopic examination of the left eye on admission was essentially negative, but shortly afterward showed blurring of nasal margins and subsequently definite papilledema; right eye, negative. Blood count showed 8200 white blood cells; 61% polymorphonuclears; 24% small lymphocytes. Results of spinal fluid examination were: Wassermann negative; globulin negative; lymphocytes 5.

Roentgen-ray findings: Bones of skull, average thickness; no evidence of increased intracranial pressure; no visible evidences of bone erosion or tumor outline; sella turcica normal. All sinuses were normal except the ethmoids, which showed slight haziness on both sides and destruction of a few anterior cells. Left orbit appeared denser than right, with slightly mottled shadow, but no bone destruction. Conclusion: The density of left orbital area suggested retrobulbar mass.

Because of deviated septum and swollen left middle turbinate, a submucous resection and removal of left middle turbinate was done on March 24. Exploration of left orbit and a biopsy of orbital tumor mass was obtained. Biopsy revealed malignancy, and exenteration of orbit was undertaken at once. This was followed by intensive radium treatment over a period of months.



Fig. 1, Case 1. Showing exophthalmos of left eye, secondary to orbital malignancy.

Examination of right eye during latter part of July showed moderate reduction in vision and low grade papillitis. During August, distinct blurring of vision of right eye occurred. Definite metastasis had taken place, not only in the right eye but to upper part of her spine. She died in latter part of November.

Comment. The findings in this case indicated a sarcoma of the orbit, although no bone destruction had taken place. The rapidity of malignancy extension emphasizes the necessity for early diagnosis and treatment.

Case 2. J. S., a white man, aged 73 years,

came under observation April 1, 1932. About 15 months previously, a red spot was noticed near the inner canthus of his left eye. The condition advanced, and a growth involved the eyeball. During those 15 months a diagnosis of malignancy had been made at another institution, where he had been under observation and treatment with x-rays and radium. Vision in this eye was lost completely 9 months before admission to our hospital.

Lids of left eye were thickened by edema to 4 times their normal thickness, and the palpebral fissure was greatly enlarged. Hard lobulated immovable masses were palpated under upper and lower lids. Slight mucopurulent secretion was present over the macerated globe and granulation-like tissue, which filled his left orbit. A small amount of iris pigment was all that remained to denote location of cornea. Right eye was negative, with vision of 6/21 and normal visual field.

Roentgen-ray findings. Entire left orbit appeared opaque, and outline of the soft tissue mass was plainly visible. Bone detail appeared partially destroyed, especially in roof of the orbit. Almost complete destruction of the ethmoid cells, and a filling-in with a mottled type of density, probably indicative of tumor tissue, was observed. There was a well-defined rarefied area in left occipital region, measuring 1 cm. x 1.3 cm., which was regarded as metastatic.

Comment. In this case, the malignancy had invaded globe, orbit and ethmoid sinuses. Metastasis had taken place to occipital region. Because of the extensive involvement, metastasis, and advanced age of the patient, active treatment by either radium, x-rays or surgery was not advised.

Case 3. J. F., a white man, aged 54 years, came complaining of double vision, which had come on about 1 week previously, following excessive drinking at a party. There was a small red blister-like elevation below inner canthus of right eye, and limitation of external rotation at the time of our initial examination. Patient did not return for examination until about 1 month later, when there was considerable swelling of the upper lid with engorgement of the vessels. Conjunctiva was chemotic, and a suggestion of proptosis was seen. Definite limitation of external, and a slight limitation of internal, rotation was noted. Left upper lid was much swollen and there was complete ptosis. Engorgement of larger conjunctival vessels and chemosis of conjunctiva



Fig. 2, Case 2. Showing exophthalmos of left eye, secondary to orbital malignancy.

were noted. Pupil was semidilated and reacted sluggishly. Ocular movements of left eye were limited in all directions.

Realizing the seriousness of the condition, patient was admitted to the hospital on November 19, 1930, with vision R. E. 6/21, and L. E. 6/15-2. There was some ptosis of right lid and complete ptosis of the left. Ocular movements were limited on outward, upward and inward rotation in right eye, and complete ophthalmoplegia was present in the left. The conjunctiva of both eyes was chemotic, and vessels of conjunctiva and retina were engorged from passive congestion. Both eyes were prominent because of a moderate degree of proptosis. Hemorrhagic retinitis developed as a result of the tremendous passive congestion of the retinal vessels. Temperature range was slightly below normal for most of the time the patient was in the hospital. Visual fields were contracted. Proptosis increased somewhat, but never became extremely marked.



Fig. 3, Case 3. Showing bilateral exophthalmos secondary to orbital cellulitis from extensive chronic sinusitis.

Laboratory findings. Blood Wassermann was negative and blood sugar 95 mgm. per 100 c.c. Blood count showed 4,500,000 red and 11,800 white blood cells. Hemoglobin was 85%. Differential count showed 60% polys; 25% small lymphocytes; 5% large lymphocytes; 9% transitional; 1% eosinophiles.

Roentgen-ray findings. No evidence of increased intracranial pressure, calcification, or erosion were detected. Sella turcica was round, size 1 cm. long and 0.6 cm. deep. Clinoids were well developed. No evidences of erosion, pressure effect or calcification of sella were seen. Frontal, ethmoid and maxillary sinuses appeared densely clouded, bilaterally. Sphenoid sinuses were moderately developed and outlines sharp and clear. Right orbital canal was larger than the left; the lower portion of its outline sharp, and the upper portion thickened and blurred. There was a mottled shadow between orbits. This appeared to be an inflammatory condition of the bone, but malignancy could not be ruled out. All remaining teeth showed abscesses. There was a general increase in density over both mastoids.

Nasal examination showed congestion of mucous membrane on both sides. Right and left middle turbinates were slightly enlarged. Foul-smelling, milky pus was obtained from both antrums on irrigation. Tonsils were infected. Foul discharge from right ear had been present for several years.

Both middle turbinates were removed and

both sphenoid sinuses opened. Right and left antrums were irrigated repeatedly and continued to discharge. Nasal septum was deflected and a submucous resection operation was performed. Ethmoid cells on both sides were removed, at different times, and biopsy made of tissue from this region was negative for malignancy. Left frontal sinus was opened externally and found to be negative. Radical operation (Caldwell-Luc) was performed on left antrum and disclosed marked hyperplastic lining membrane, polypoid formation and pus. Remaining teeth were extracted. Right ear was treated by irrigations. Nasal and sinus operations were performed by Dr. Whelan, in the associated nose and throat clinic of the Wills Hospital.

After these various operative procedures, patient began to improve. Proptosis and paralysis of ocular muscles subsided. Fulness of retinal veins and hemorrhagic areas became less. Vision was improved to R. E. 6/12 and L. E. 6/9 at time of last examination in the early part of 1932.

Comment. The bilateral proptosis, chemosis and swelling in this case were suggestive of malignancy in the interorbital region, probably the ethmoids, with bilateral extension into orbits. The extensive infection of the various sinuses, partly chronic but with superimposed acute infection, extended into and involved the orbits in a violent cellulitis; the right orbit first, with more gradual later involvement of the left. The improvement following operations on the sinuses definitely excluded malignancy.

Case 4. J. D., a young man, aged 24 years, came under observation in February 1931, complaining of swelling below the inner half of his right brow. Right eye was displaced downward and outward, and its prominence, first noticed about 6 months previously, seemed to be slowly increasing. No pain complained of at any time. No discharge from nose was detected.

Vision in R. E. 6/12 and L. E. 6/6; wearing R. E.—2.75 Dc. ax. 180°. Right upper lid was swollen and a mass 1.5 cm. in size, of fleshy consistency, was palpated above inner canthus below eyebrow. Right globe was proptosed down and out; limitation of upward rotation, rather marked. No pain could be elicited by palpating over mass. Right frontal sinus was dark to transillumination. Fundus examination of both eyes negative.

Roentgen-ray findings. Marked cloudiness of right frontal was readily seen. This appeared to be a chronic, inflammatory condition, but malignancy could not be definitely excluded.

Was admitted to hospital for operation March 10, 1931. External radical operation on right frontal and ethmoid was done, and right sphenoid was opened by Dr. Fielding O. Lewis. Incision was made below eyebrow to floor of frontal sinus, where pus was obtained; having broken through floor of sinus and, extending backward, become a retrobulbar abscess. A large quantity of foul-smelling, thick, greenish pus was obtained. Patient was in hospital 1 week and made an uneventful recovery. Proptosis decreased rapidly. The myopic astigmatism diminished gradually until finally none remained. Vision was 6/5 without correction at time of last examination.

Comment. The firm mass of flesh-like consistency was suggestive of malignancy, which the x-ray findings did not exclude. The operation disclosed a frontal sinus abscess extending into orbit.

Case 5. S. J., a white woman, aged 45 years, came complaining of pain and swelling of left eye, which had begun 2 months before, following an acute cold in head. This continued for 6 weeks, when pain and swelling became much more severe.

Examination showed edema and swelling of both lids of left eye, so that they could be opened only with effort. Congestion of both orbital and palpebral conjunctiva was present.

The globe showed an exophthalmos of 6 mm. Ocular movements were limited in all directions. Visual fields were full. Vision in R. E. 6/6 and L. E. 6/15, with proper correction. Temperature range was slightly above normal. Patient seemed stuporous part of the time in hospital.

Laboratory findings. Urinalysis negative. Blood Wassermann, negative. Blood sugar 129 mgm. per 100 c.c. Blood count, 4,150,000 red

cells; 9500 white; hemoglobin 75%; polys. 63%; small lymphocytes 23%; mononuclears 2%; transitional 5%; eosinophiles 1%.

Roentgen-ray findings. Left orbit appeared denser than right; the shadow hazy and homogeneous. Left ethmoid nearly opaque; cell walls greatly thickened, with considerable destruction; maxillary sinuses clear in outline.

Incision for drainage of left orbit was done without obtaining pus. Left ethmoid and left sphenoid were opened with the production of little pus. Left antrum was irrigated and a large quantity of pus obtained. Irrigations of antrum were repeated, and a small opening was made beneath inferior turbinate to allow freer drainage.

Following these measures, proptosis subsided and vision improved.

Comment. The infection of left ethmoid sinus extended into orbit, giving rise to orbital cellulitis with the resultant exophthalmos. The infection of left maxillary antrum was secondary, probably, to the ethmoid sinus infection, and also a contributing factor to the orbital cellulitis.

Conclusions. The exophthalmos caused by malignancy of the orbit must be diagnosed early so that prompt radical measures, followed by radium and x-rays, may be instituted, in order to conserve life. Exophthalmos with extensive malignancy is hopeless, and energetic treatment may cause fatal reaction. The differential diagnosis between exophthalmos secondary to malignancy, and that secondary to orbital cellulitis, shortly after onset is difficult, but important. Abscess of frontal sinus may produce an exophthalmos simulating malignancy of the orbit.

DISCUSSION

Dr. A. Rados (Newark): The diagnosis of exophthalmos is very simple in unilateral cases; but in bilateral cases, and especially during the early stages, the diagnosis may be very problematic, as it is based upon the interrelation of the corneas of the 2 eyes. The position of the eyes within their sockets shows a physiologic variety of wide latitude. From the underlying principle regulating the intra-orbital position of the eyeball they fall into 2 groups, active and passive. Let us analyze these separately:

(1) *Active.* (a) *Propulsion.* Filling of the orbital vessels, to a lesser degree the arterial; to a greater degree, the venous system. Any pathologic changes arrogating space, such as mucocele, tumor, bleeding, subperiosteal abscess. (b) *Protraction.* Action of the oblique muscles. (c) *Retraction.* Action of the straight muscles.

The second and third (b and c) of the group are antagonistic in their actions. (d) *Repulsion.* Contraction of the orbicular muscle of the lids, of the levator palpabrae, and of Mueller's muscle causing a stretching of the orbital septum.

(2) *Passive.* (a) *Propulsion.* The tarsoörbital septum, and further, in case of a marked protrusion, the optic nerve and fascial part of the muscles. (b) *Repulsion.* The fascia particles of the muscles.

The strength, variation and modification of the above principles are responsible for the various positions which the eye assumes in relation to the bony margin of its socket. By way of elucidation, let me mention briefly a few instances, such as the retraction in old individuals being due to lesser amount of orbital fat and decreased blood pressure. Width of the palpebral fissure (cocaine, sympathicus, oculomotorius) may cause an exophthalmos of 1 mm., due to marked contraction of the levator palpebrae. Stimulation of sympathicus (cocaine), paralysis of vasomotors, will cause a slight exophthalmos as well. Paralysis of sympathicus (Horner or Dejerine-Klumpke symptom) will inevitably result in exophthalmos associated with atrophy of the retrobulbar fat.

I want to avoid discussion of the general pathology of exophthalmos, and to take into consideration only the 2 points brought out by Dr. Mengel.

In relation to rhinogen exophthalmos, we have to mention the mucoceles of the frontal and ethmoidal sinuses, the latter very often simulating a dacryocystitis. The inflammatory changes of the sinuses may result in anterior or posterior ostitis, and orbital periostitis, subperiosteal abscess or peri-orbititis. Progression into the socket may be caused by direct communication between sinus and orbit, or infectious periphlebitis or thrombophlebitis. The symptoms vary accordingly as single or multiple affections of the sinuses are instrumental here and, furthermore, the clinical picture has to produce variations depending upon the orbital pathology caused by the former. An anterior orbital peri-ostitis, for instance, will result in swelling and redness of lid and conjunctiva without the production of proptosis. On the other hand, a posterior peri-ostitis will invariably produce an exophthalmos with dislocation and limited movements of the eyeball in addition to the pain and inflammatory symptoms. In marked cases these symptoms will guide us in the differential diagnosis from tumors. Nevertheless, I have to admit, that the differentiation meets in some cases with extreme, and at times almost insurmountable, difficulties. There are border-line cases, such as tumor causing the sensation of pain on the one hand; and chronic inflammatory changes failing to produce the stormy symptoms outlined above, on the other. The presence or absence of increased temperature, the blood picture, sedimentation test, etc., all are to be considered.

The differentiation between posterior peri-ostitis or thrombophlebitis (phlegmon, abscess) is still more difficult.

The exophthalmos caused by tumor produces a picture that varies according to the origin of the tumor in the orbital tissues, or whether it invades the latter from the sinuses.

Pain due to pressure on the sensitive nerves may accompany tumors, especially those of rapid and infiltrative types. Diplopia may be present, it may even give the first inkling of malignancy of the sinuses. The exophtha'mos itself, however, shows

in this group an exceedingly wide range of variation depending upon location, size and histologic structure; but the outstanding characteristic is given in its slow progression. The tumors of the muscle-funnel will cause an exophthalmos in the optical axis without lateral dislocation. The latter will point to involvement of the bony wall. The difficulty in obtaining a definite time history of the beginning of the proptosis often leads to mistakes in case of unilateral myopia, or of unilateral Basedow's disease. The lateral impression and flattening of the tumors produces a very marked symptom in refraction: a myopia, respectively myopic astigmatism. But the refraction may change to hypermetropia also, as in one patient whom I observed years previously, where a tumor in back of the eyeball through impression of the posterior pole caused a marked hypermetropia in certain positions of the eye. X-rays give very reliable results especially in cases of osseous tumors.

Before closing these very incomplete remarks, I would like to mention briefly only one condition which we encounter, time and again, where the clinical manifestation warrants the diagnosis of some tumor within the eye-socket, and operation and the following histologic examinations do not reveal presence of tumor, but only some inflammatory, dense tissue of unknown origin, and where the exophthalmos persists indefinitely by lack of clinical symptoms of inflammation.

Dr. J. S. Shipman (Camden): I just want to express to Dr. Mengel my appreciation of that paper, which he so ably presented, and to speak about 1 patient whose record he gave you, whom I had the pleasure of seeing. It was the young man with infection extending from the ethmoid cells and frontal sinus, causing a marked displacement of the right eye, down and out. I saw that man before he was operated on, and I think Dr. Mengel deserves credit for his speedy diagnosis and correct treatment, for certainly, from clinical examination, it looked very much like a tumor. The beautiful result he obtained is the consequence of his extraordinary examinations, his nose and throat examinations, and the treatment that he instituted, and deserves mentioning because the man did get a beautiful result, both functionally and cosmetically.

Dr. Wallace Pyle: I would just like to say that there is difficulty sometimes in diagnosing between the exophthalmos of paralyzed muscles and a new growth in the orbit. The case I have in mind is one of a man aged 72, who had always been a good liver and a hard worker. He gradually developed a paralysis of an external rectus muscle. This went along for almost a month; no exophthalmos. Then he developed a paralysis of all the other extra-ocular muscles, and I began to see a slight exophthalmos. The fundus was normal and vision was normal. About the time that he began to develop exophthalmos he had some congestion of his veins in the fundus, and the subject came up then as to the possibility of this being a new growth behind the eye. I had him see Dr. Knapp, and Dr. Knapp agreed with me that it was just an exophthalmos from the paralyzed muscles.

It was very hard to keep this man quiet and satisfied with that diagnosis.

There is another point in the treatment of the exophthalmos of children from accessory sinus infections that I would like to bring up, and that is the good results that I have obtained from use of the Loré suction apparatus. I have never seen it work in adults, but I have now 5 different cases of small children who have had inflammation in the fat behind the eyeball following an acute suppurative sinusitis, that have all been completely, wholly and unqualifiedly cured by use of the Loré suction apparatus with plenty of negative pressure, preceded by adrenalin, so that the exophthalmos has subsided; the swelling and redness in these eyes have all disappeared; all have had normal vision restored.

JAUNDICE IN INFANCY

Walter B. Stewart, M.D., F.A.A.P.,
Atlantic City, N. J.

This study of the occurrence of jaundice in infancy will be introduced by a review of current opinion on its pathogenesis, a phase of the subject which has been reviewed recently by Rich. The cause of jaundice is the presence in the blood stream of bile pigments, especially bilirubin, in excess of normal, threshold amounts. The only known source of bilirubin is the hemoglobin derived from erythrocytes which have been destroyed. Reticulo-endothelial cells, which are anchored within the capillaries of the spleen, the liver, and the bone marrow, engulf the fragmented erythrocytes. The contained hemoglobin is split into bilirubin and a colorless, iron-containing product, both of which are discharged into the blood stream. In passing through the capillaries of the liver, the bilirubin is excreted by the epithelial cells of the liver into the bile canaliculi, and thence is carried through the larger bile ducts into the intestine. There it is reduced by bacterial action to urobilin, some of which is excreted in the stools, and some absorbed by the blood, whence it passes back through the liver, or, in case of depressed function of the liver, into the urine. The nature of the bilirubin in the blood plasma can be determined by the van den Bergh test. An indirect or delayed reaction indicates bilirubin which has not passed through the cells of the liver, hence is not mixed with the constituents of the bile. A direct reaction indicates bilirubin which has passed through the cells of the liver and, because of either obstruction in the bile ducts or necrosis of the cells of the liver, has passed from the ducts back into the blood stream.

The inspiration for this study of jaundice during early life was the occurrence in an infant, aged 8 months, of intense jaundice, only 4 days after the onset of a streptococcic lobar pneumonia, fatal on the fifth day of illness. Streptococcic hepatitis was the cause of jaundice in this case. The relative rarity of this variety of jaundice has induced an etiologic survey of recent literature on other varieties which may occur in infancy.

The form seen most frequently is icterus neonatorum, present in 1/3 to 1/2 of all newborn infants, and of physiologic rather than of pathologic significance. The jaundice does not appear until the second to the fifth day, rarely later, and seldom persists for more than 10 days. It appears first on the face and chest, later on the conjunctiva and perhaps elsewhere. There is no associated change in the color of the urine or the stools. Many etiologic theories have been advanced, of which the most widely accepted is that of Goldbloom and Gottlieb. It is well known that there is a physiologic polycythemia in the fetus, since the erythrocyte and the hemoglobin figures for the new-born are abnormally high. During the first few days after delivery there is a rapid fall in the erythrocyte count and in the hemoglobin, and a simultaneous development of jaundice. The fetus resembles a person with congenital heart disease in the low oxygen content of the blood and the compensatory polycythemia. The change to normal oxygen content after delivery and the destruction of excess blood causes an increase in the plasma bilirubin and, in many cases, the development of icterus neonatorum. Since there is a constant disintegration of erythrocytes in the normal individual and a resultant constant formation of bilirubin, there is a small quantity of bilirubin present normally in the blood plasma. If the amount is increased above the threshold limit, clinical jaundice ensues. Blood taken from the umbilical cord always gives an indirect van den Bergh reaction. Every newborn child, then, has icterus, although only 1/3 to 1/2 have jaundice. In the cord blood and in the peripheral blood there is an abnormally large number of immature and nucleated erythrocytes, and of reticulated forms, and also an increased fragility of the red corpuscles, returning to normal at the end of a week. In a word, spontaneous hemolysis in immature blood has produced jaundice.

It is well known that icterus neonatorum occurs more frequently, and that it is of greater intensity and longer duration, in the premature than in the full-term infant. There is evidence that even in the latter the excretory power of the liver is subnormal during the early days of life, since the organ is unable to excrete properly the dyes used to test its excretory function. This deficiency is the result of immaturity and explains the increased frequency of jaundice in the premature infant. Hence, the intensity and duration of the jaundice depend not only on the amount of hemolysis that has occurred but also on the degree of maturity and the excretory sufficiency of the liver cells. There are, then, 2 factors which must always be considered in relation to the production of jaundice; i. e., the amount of bilirubin produced and the ability of the liver to excrete it.

Infection is an important cause of jaundice during infancy. The streptococcus was the etiologic agent in the case of hepatitis previously mentioned in an infant, aged 8 months. Both factors were present: excess production of bilirubin, as a result of the hemolytic action of the streptococcus; and depressed excretory power of the cells of the liver, as a result of anoxemia and cellular degeneration. The recent study of streptococcic hepatitis by MacMahon and Mallory has shown the frequency with which the liver is attacked by the streptococcus in the form of an acute, nonsuppurative hepatitis. A similar lesion may be produced in septic jaundice of the newborn by bacterial, usually streptococcic, invasion of the liver by way of the umbilical cord. The umbilicus may show no external signs of inflammation, in which case the prognosis is poor. However, in no case is it good. Jaundice appears on the second or third day, is of increasing intensity, and is often accompanied by a cyanosis which gives the skin a peculiar brownish color. A milder case, with damage confined chiefly to the connective tissue of the liver, may furnish the initial lesion of a subsequent hepatic cirrhosis.

Icterus gravis is a term which indicates nothing more than a rapidly supervening jaundice accompanied by symptoms of intense intoxication and by a severe involvement of the central nervous system which leads to death within a short time. Pathologically, there is a diffuse necrosis of the cells of the liver, especially in the central areas of the lobules, a picture identical with that of acute yellow atrophy. In some cases of icterus gravis the jaundice is merely a symptom of sepsis; in others, there is a familial predisposition, and it is designated as familial icterus of the newborn. In this condition a brief but intense jaundice, occurring in successive offspring of the same mother, leads to a fatal termination, although an occasional child may be born healthy and remain healthy. The recurrence of the condition in subsequent pregnancies has been prevented by the administration to the mother during the final 10 weeks of gestation of 100 gm. of liver daily, in which case little or no jaundice has resulted. Recent hematologic studies of these infants by Buhrman and Sanford have revealed blood findings apparently identical with those of erythroblastosis. There is a severe anemia, a large proportion of nucleated erythrocytes, and enlargement of the liver and the spleen. The indirect van den Bergh reaction indicates destruction of blood. Necropsy reveals active erythropoiesis in the liver, spleen, and bone marrow. Hence, the erythropoietic system of these infants with familial icterus has not yet developed beyond the fetal state. If a generalized edema is present at birth in association with this condition, it is known as hydrops congenitus.

Familial icterus of the new-born, or erythroblastosis, must be differentiated from the erythroblastic anemia of Cooley. The age of onset is later in erythroblastic anemia, usually 1½ years, and the condition develops only in children of Greek or Italian parentage. Although there is a vague yellowish tint to the skin, jaundice is not a feature. The abdomen is greatly enlarged, because of enlargement of the spleen and, to a lesser extent, of the liver. There is a large number of nucleated erythrocytes present, as there is also in erythroblastosis. There are characteristic roentgenologic changes in the bones. No patients have been known to recover.

Another hemolytic variety of jaundice which one occasionally sees in an infant is congenital hemolytic anemia, often designated as familial hemolytic jaundice. The following characteristics distinguish it from erythroblastic anemia: absence of a distinct racial incidence; presence of visible jaundice; the large number of reticulocytes and small number of nucleated erythrocytes; and, the increased fragility of the erythrocytes. Recovery after splenectomy is the rule.

Jaundice of the obstructive type is present in congenital obliteration of the bile ducts and in catarrhal jaundice. In the former, jaundice may be present at birth or may not appear before the lapse of several weeks, but is of increasing intensity. Bile pigments are present in the urine but not in the stools. The liver and the spleen are enlarged and firm. It is always fatal, although an occasional child may live for more than a year. At a recent meeting of the Philadelphia Pediatric Society, J. M. Deaver reported a case of congenital absence of the extrahepatic ducts and the gall-bladder, in which jaundice did not develop until the age of 6 weeks and in which death came at the age of 1 yr. 12 days. Many anomalies of this type are possible, such as atresia of the intrahepatic but not of the extrahepatic ducts; or, atresia of the common duct with normal cystic and hepatic ducts. Rolleston postulated as the cause an intra-uterine inflammation from maternal toxins, leading to cholangeitis and atresia. In all these cases there is an associated biliary cirrhosis.

Catarrhal jaundice is a more serious illness in infancy than it is in later childhood, although most infants recover. The pathologic picture of the liver was not known until the studies of Eppinger, who was able during the World War to examine the liver from 3 soldiers killed in battle who at the time had catarrhal jaundice but were not disabled. Except for enlargement, the livers were, grossly, normal; but microscopically the parenchymal cells were seen to be distorted, poorly stained, and with deformed nuclei. The central vein occupied an

eccentric position, and the normal arrangement of the cells was somewhat disturbed. Between the cells there was nuclear detritus. In a word, there was degenerative involvement of the parenchymal cells. One can readily see how recovery from such a condition may leave behind the initial lesion of a subsequent cirrhosis. The etiologic toxic factor is not known. The symptoms, sufficiently well known, need no discussion.

Cirrhosis of the liver in the infant and the child is not so rare a condition as one might suspect. The most recent studies on this subject are those by Calvin and Saffro, and by Bridgeman and Robertson. The first named authors presented a series of case reports found in American literature, in which enlargement of the liver was present. There were 5 patients in the first year of life, in 4 of whom jaundice was present; and it was present in 3 out of 5 patients in the second year of life. Bridgeman and Robertson reported an instance of hypertrophic cirrhosis in an infant aged 6 months, in whom the liver had become atrophic before death at the age of 26 months.

One important cause of cirrhosis is obstruction in the bile ducts, such as one sees in infants with congenital obliteration of those ducts. A preceding attack of catarrhal jaundice seems to be of etiologic significance in certain cases. Alcohol may be the cause of cirrhosis, especially among the foreign-born. Elterich reported a child, aged 3½ years, of Italian parentage, who at the age of 10 months received as a tonic for 25 days 1 tablespoonful of whisky in 3 tablespoonfuls of water. Later, she drank whisky whenever the father had it. During the 20 days before admission she had taken 1 quart. The liver was greatly enlarged. In some cases, preceding infectious disease, especially measles and scarlet fever, may be of etiologic importance. Henoch observed proliferation of portal connective tissue and dilatation of the small ducts, a form of hepatitis which he considered capable of developing into a true cirrhosis. Mogk reported a case of cirrhosis in a young child who, 8 weeks before death, had a severe attack of scarlet fever. Section of the liver showed irregular areas of necrosis and proliferation of connective tissue. Chains of streptococci were demonstrated within the more recent lesions. However, these hepatic lesions secondary to specific infectious diseases must be the exception rather than the rule, since one of the interesting characteristics of the liver is its resistance to acute infection, a resistance not shown by any other organ. Hypertrophy and atrophy of the liver should be regarded, in most instances, as successive stages of the same degenerative process. Hypertrophy is caused by cellular degeneration, fatty infiltration, and cellular proliferation; atrophy is caused by the reparative proliferation and the subsequent contraction of fibrous tissue.

The youngest recorded instance of atrophic cirrhosis has been described by Dickson. The infant developed jaundice during the second week of life, which persisted and intensified until death at the age of 5 months. Nutrition and growth were entirely normal during this period. Enlargement of the liver and the spleen was observed during the third month. Jaundice was the only outstanding symptom until the terminal ascites and coma. At necropsy the liver was small and contained no normal hepatic tissue. There was a subacute diffuse necrosis and nodules of hyperplastic liver cells.

The development of jaundice is relatively rare in congenital syphilis, although the liver is frequently affected, since intercellular cirrhosis rather than obstructive cholangeitis is the characteristic lesion. When it does occur, a deep jaundice is usually present at birth.

Briefly, then, one may say that jaundice in the early months of life becomes a symptom of importance only when it is intense, progressive or persistent, and accompanied by other clinical abnormalities. If jaundice, apparently of the icterus neonatorum type, persists for 1-2 months, we should not necessarily give a bad prognosis. Still has recorded the recovery of several such patients. However, the ultimate prognosis should be guarded, since it can scarcely be called a physiologic icterus.

Summary

The differential diagnosis of jaundice in infancy may be difficult and the prognosis uncertain. The following statements should be

useful in reaching an accurate conclusion: Icterus neonatorum develops in about 1/3 of all new-born infants on the second to fifth day of life, and persists seldom longer than 10 days. If it is present at birth, appears after the first week, or persists beyond the second week, other causes must be considered. Of these, infection is the most important. Fever, although not always present, jaundice of deepening intensity, indications of infection at the naval, and the toxic appearance of the infant, may be additional points of evidence for infection. Jaundice as a symptom of sepsis has been too frequently overlooked. A history of the death of jaundiced siblings soon after birth leads one to suspect familial jaundice of the new-born, now known as erythroblastosis. The jaundice of congenital hemolytic icterus is never intense, and may appear at or shortly after birth. There is an hereditary history and an increased fragility of the erythrocytes. An obstructive jaundice, with urine which stains the diapers, and stools of the clay-colored variety, indicates either congenital obstruction of the bile ducts or catarrhal jaundice. The latter is accompanied by fever and vomiting and will clear up within 1-2 weeks; the former is progressive. In cirrhosis of the liver, jaundice develops during the later stages of the process and is accompanied by the usual symptoms. Biliary calculi in children are extremely rare. Syphilis, although usually mentioned, is seldom the cause of jaundice.

DISCUSSION

Dr. Frederick W. Lathrop (Plainfield): I was intensely interested in Dr. Stewart's comprehensive and descriptive portrayal of jaundice during infancy. Persistent jaundice, lasting more than 2 weeks, must be recognized early as being more than a physiologic icterus neonatorum. These more serious conditions which Dr. Stewart has described occur often enough so that we must be ready with differential diagnosis.

Accurate diagnosis is important, because certain of these patients require radical treatment to effect the saving of life; I refer particularly to surgery for correcting congenital atresia of the bile ducts. I was disappointed that Dr. Stewart dismissed this procedure so lightly. The cirrhosis found at autopsy often appears only secondary to the biliary stasis. While some do have an intrahepatic anomaly of the biliary system, there are more whose pathology is limited to portions of the ducts which can be reached surgically. Ladd, in 1928, found 8 patients out of 20 amenable to operation, and had complete recovery in 6 of those 8. If a connection can be made between the hepatic duct and the stomach or duodenum, the infant will be cured and will develop normally. The worst surgery can do is to hasten an already certain lethal outcome. In favorable cases it will save a life. I should like further discussion concerning this procedure.

Recent work showing that familial icterus of the new-born is an erythroblastosis, primarily a disease of the blood and only secondarily jaundice, may lead to methods of prevention, and Dr. Stewart mentioned feeding liver to the pregnant mother if there existed a history of erythroblastosis associated with previous pregnancies.

Dr. William London (Perth Amboy): I just want to mention the story of 2 families I have taken care of, in which there existed congenital and familial jaundice of the non-hemolytic type. One family had 2 children perfectly normal and then, after an interval of some years, the woman had 4 successive pregnancies. I took care of, until they died, all those 4 children, in whom this rather rare condition developed and all ran exactly the same course. They were apparently perfectly normal infants, but sometime during the first week they began to develop jaundice; the liver became progressively larger; the spleen came down a bit; the jaundice deepened; there was bile in the stools; the urine was deeply bile-stained; and death occurred from as early as 2 weeks to as late as 3 months. The children were all followed along very carefully; Wassermann was negative on both parents and all of the infants; 1 child came to autopsy and the only changes found were those described by the pathologist as "signs of an interstitial hepatitis"; and blood findings were a decreased fragility of the red cells. They developed a moderate degree of anemia, not severe.

In the other family, the mother had 3 successive pregnancies but no child lived. The first died within 2 weeks. Jaundice developed at about the end of 3 days and ran exactly the same course as described in the first family. The second child went on to 3 months of age, and the third ran a rather unusual course. The child developed jaundice at the end of a week. For the first week it was thought to be a normally healthy child, as it gained weight and did perfectly well, even after the jaundice began. Then the liver became very much enlarged, but that child went on to 8 months of age, developing a progressive anemia but of the non-hemolytic type. The blood studies also showed in that case decreased fragility of the red cells and progressive anemia. The child died after having had several futile transfusions. It also came to autopsy and the only pathology reported in the liver was a generalized interstitial hepatitis. In that family also the Wassermann was negative for parents and children.

Dr. A. W. Bingham (East Orange): I am very much interested in this matter and would like to ask the last speaker if he tried any treatment to prevent jaundice in the succeeding births? I have used protiodide of mercury with some success in such cases. I am not sure of the reason for that success, if there is a negative Wassermann, but it does alter the condition of the blood. Also, I would like to know something more about liver extract. Has any one any statistics regarding its effect, or is liver extract just being tried out?

Dr. William London (Perth Amboy): The first child of the first family was given antiluetic treatment, in spite of the negative Wassermann, but after that no such treatment was given and the

other children died without any special form of treatment being attempted.

Dr. Julius Levy (Newark): I want to ask whether any relation was noticed between asphyxia of the new-born and the presence of icterus? It has been pointed out in a large series of autopsies that icterus is, as Dr. Stewart stated, the result of sepsis but also that the asphyxia causes hemorrhages into the organs and thereby increases the liability to infection. It would be interesting to realize, then, that one method of reducing death from icterus would be to reduce asphyxia.

Dr. Walter B. Stewart (closing): I have not noticed any association between cases of icterus and asphyxia but there may well be such a relationship in some instances.

PROBLEMS FOR THE DOCTOR*

F. I. Krauss, M.D.,
Chatham, N. J.

I have deeply appreciated the honor of being President of this Society for the year 1931-32. It has been a privilege to have become better acquainted with you as individuals and to have worked with you officially. In particular, I wish to thank the members of the Executive Board for complete coöperation. Several problems have arisen where personal feeling could easily have supplanted judgment. It is to their credit that they have always considered the dignity of the Society first. The most difficult position in any society is that of Secretary. The real success of its activities depends more upon him than upon any one else. He arranges your meetings, takes care of a vast amount of correspondence, and must see that progress in scientific knowledge and sociability go hand-in-hand. We have been extremely fortunate in our secretaries.

The Constitution states that the President must address the Annual Meeting; otherwise this evening would surely have been given over to a more interesting program. I would present 3 particular subjects, grouped broadly as *coöperation, specialism,* and the position of *the general practitioner.*

In discussion of coöperation, I may not be politic but I am much in earnest. I have given thought to this phase of our professional life for many years. No organization ever existed where everything was harmonious; there must be differences of opinion, for there cannot help but be personal likes and dislikes. Because medicine is the broadest and noblest profession in existence—and I say this with all due respect to all other professions—there should be less evidence of prejudice among medical men than anywhere else in the world. The doctor, as an individual, is an idealist without a film over his eyes. He knows human nature from its sublimities to its tragedies. The mature physician has no illusions, yet by and large he is a supreme optimist. However, we are human enough to be constantly in danger of that great destroyer of happiness—jealousy. An honest recognition of its dangers is safety insurance. As young men full of enthusiasm come here for their life work, they must not be allowed to feel that they cannot trust their professional colleagues. It is so easy to make remarks which can hurt another. Eventually, they are boomerangs which return to the thrower, but in the interim they cause a lot of pain and damage. Because young men have talked to me about this, and because we have all had personal experience, I make bold to call it to your attention. We older men set the pace, we hold our places for a few years and then are forgotten or are pushed aside. We ought to be more than generous, we ought to encourage and praise. We do not own our patients; they are at perfect liberty to seek advice where they desire, and whether we coöperate, or not, they will do so. They will go where their friends or neighbors suggest; they will leave for some fancied dislike or whim; and they are particularly keen to note an aspersion made by one doctor about another. We ought to recognize this honestly. When a patient leaves, the new physician is not *stealing the case.* The man left has not, necessarily, failed nor made a mistake; he does not need to go about with bitterness in his heart and refuse to be courteous to his competitor. We *are* competitors, but we can be fair to one an-

*(Read by the retiring President at the Annual Meeting of the Morris County Medical Society, September 29, 1932.)

other. How much better it would be if we could say: such and such a patient came to me and I assured that patient that you would be glad to coöperate, because you had previously studied his condition and may have some valuable knowledge which will be of mutual benefit. That patient would thus learn to trust both doctors and to have a higher regard for the medical profession.

A frequent cause of misunderstanding is due to taking care of a patient when the family physician is away, either for a few hours or on a vacation. Emergencies come under the same classification. It is sometimes very difficult to send such a patient back, for he either takes the attitude that the physician who started the treatment ought to finish it, or a greater preference is formed for the present attendant, or he does not care. Sometimes he is annoyed because he could not have his own doctor when he wanted him. Also, do not forget the chronic dead-beat who is making the rounds. Whatever the reason, the newly taken doctor can very easily encourage it, whereas he should make every effort to send that patient back to his first doctor. He certainly has *a right* to keep that patient if he wishes, but his finer ethics should make him do all he can to protect the interests of his fellow doctor. If this fails he need have no hesitation to report the occurrence. As our population increases we see less and less of such a code. However, it is practical; I have seen it work out; and where it does prevail there is a wonderful spirit among that medical group. The people also appreciate the doctors sticking together and, in consequence, they are more highly respected.

Jealousy is also encouraged by *closed hospitals*. Remember that hospitals are maintained primarily in order that the people may have better care. It is contrary to this principle to restrict the facilities of a hospital to any special group of men. Each hospital must necessarily have its official Staff, but the use of every hospital should be available to any physician in good standing to care for his private patients. Many men will disagree with this standard. Let me illustrate the spirit involved. About 2 years ago the Medical Board of a neighboring hospital, whose facilities had always been available to reputable physicians, sent a circular letter to all the other hospitals whose physicians were using its operating rooms, asking if they were willing to reciprocate and extend the same courtesy to this hospital's full staff of attending physicians and surgeons. Out of about 10 hospitals 3 replies were received, only 1 of which agreed to this reciprocation; the other 2 stated frankly that they were *closed hospitals*.

This hospital decided, therefore, to become also a closed institution. This is not a healthy spirit. It does make the running of the hospital easier; it does force patients to have a local physician, unless they wish to go to the annoyance of going out of town; but, it keeps physicians apart, encourages a narrow-minded attitude, discourages innovation, and prevents the growth of knowledge.

The closed hospital is an injustice also to the new physician. The recent graduate, with an intern service of 1 or more years, is granted a state license to practice medicine and surgery. He joins the County Society. He is in good standing. Before long he has a private patient with a surgical condition which needs hospital care. Probably no hospital will allow him the use of its operating room. The patient must be entered under the responsibility of some one on the Staff. This, I believe, *is not fair* either to the physician or to the patient. The mere removal of the patient from home to hospital disqualifies that physician. He is legally responsible for what he does and is not likely to attempt something he cannot finish. His reputation is at stake, not the hospital nor its Board. Give him a fair opportunity to build up a practice. If you do not, his reaction is something as follows: when, after years of hindrance, he is allowed hospital privileges, he will be like a sophomore in college and think it is his privilege and opportunity to lord it over the next new-comer. Thus, you create a vicious circle. I have been in practice long enough to know that the training of some of our physicians and surgeons of note cannot compare with the training of most of our recent graduates from

our schools and large hospitals. *These young men are well worthy of our respect.*

The standing of the medical man in the economic and professional world is at present causing us much concern. The corner-stone of the entire medical structure is the family doctor. All others are sub-divisions, annexes, or merely facades. Frequently these attract all the attention, and are likely to be puffed up with their own importance. In this present era, when everyone is getting back to reality, the opportunity has come for the general practitioner to re-assert his rightful position. He is to be censured for having given it up too easily. It was comfortable to shift responsibility to other shoulders. Money was free, patients would ask for consultations without regard to expense, and were not willing to give him the time or the opportunity to develop his case. The doctor got in the habit of asking in the beginning for assistance, often to avoid possible censure. The consultant would have all the glory, rarely the blame. This caused an inferiority complex among general practitioners. It is all wrong. There are very, very few conditions that a well trained man cannot care for. All he has to do is to put his mind to it. He should not be afraid to tell his patients that he is responsible, and that if he needs help he will obtain it from the right source. He should do what surgery he is qualified to do, set fractures, remove tonsils, open ears, remove appendices. There is nothing mysterious about this work. These routine things are not specialties. The average surgeon in our towns takes care of patients with pneumonia, or measles; why not reverse the situation?

When anything new comes up, immediately the statement is issued that special training is necessary. This occurred with the treatment of syphilis, the giving of toxin-antitoxin, Schick tests, diathermy, insulin, and so on. Any physician with initiative, knowledge, a little courage and self-confidence, can quickly learn new methods. There always has to be a first time. The consultant that you call made his reputation by that very means. Remember that the older specialists worked their own way up from the position of general practitioner, and the difference in knowledge and ability can be bridged if you desire.

Our State Society has recently adopted a wise law concerning the registration of specialists. The ethical problem involved is not only the protection of the public, but, just as important, the protection of the general practitioner, from the man who specializes and does general work also. Those who have built up a specialty from general practice, and those who are still taking new patients in the general field, have a problem to solve which will bear serious consideration on their part. Some men make the defense that they are doctors first and specialists secondarily, and that if patients want them they ought to take care of them. This argument, always weak, will not stand up in the future. Any man who receives his certificate must have a very good reason for taking any patient outside his field. There must be a strong sentiment developed in the profession if this plan is to succeed. We doctors must see to it that this aspect of the new law is ethically supported. Could not our own County Society take the lead in sponsoring this position?

The economic value of the profession depends on the respect which the public gives. Any one who respects your services is willing to pay for them. The moment that *respect* and *confidence* decrease down goes the economic value. One doctor then becomes as good as another, all on the level of tradesmen. This encourages the growth of *state medicine,* and the subservience of the profession. People and politicians know that they can buy cheaply. Quality does not interest the politician. Buy so many doctors, and then tell the voters what they can have free. This pernicious propaganda has made the public feel that medicine is not a legitimate expense. It is particularly blatant at present. Patients frankly tell us that because of cuts in salary they cannot pay, yet we know that other bills are paid, new automobiles are purchased, vacations are taken, new styles in clothing are followed. We are regarded as a super-luxury, to be paid for if convenient. I believe it is partly because the individual doctor and the profession as a whole have not maintained the stand-

ard of respect due. We have been too anxious and too willing to give our services promiscuously to public charity and to organized welfare in its various branches. We are now being devoured by our own monster.

It is almost, but happily not quite, too late to come back. Let us do our individual charity work gladly as we have always done. Let the public understand that the time of exploitation of the doctor, in the hospital, in the clinic, in the social service work, is past. The doctor is entitled to compensation for his public welfare work; by no stretch of the imagination is this his duty any more than that of any other citizen. It is high time to insist upon this, not because it is a burden, but because its abuse has led to the point where private practice medicine is in danger of extinction.

The place to discuss these problems is in the County Society. Do not stay away because you may not happen to be interested in some particular paper. The surgery of today is being replaced by the therapeutics of tomorrow. Degenerative disease of old age has its inception in childhood. Arteriosclerosis, glaucoma, arthritis, may soon yield to a new knowledge of biochemistry. Each specialty is intimately interwoven with general medicine. Each is one pigment in the painting. Increase in knowledge, professional and personal good will, and economic stability depend upon your loyalty to your organization.

AS THE DOCTOR SEES HIS PROFESSION

E. G. Hummel, M.D.,
Retiring President of the Camden County Medical Society,
Camden, N. J.

I consider it a great honor tonight to address, as President, one of the oldest Medical Societies in the United States. It is no mean privilege to have been associated with such a society, and to have served in the office of President, when one considers the back-ground and character of this Society. There is usually an interest attached to the back-ground and history of things. They throw light and understanding upon events and persons. We can appreciate, and are even amused at, the 5-year-old daughter of a radio announcer, who having been asked to say grace, prayed thus, "This food comes to us through the courtesy of Almighty God. Amen." Though not amusing, it is interesting to know a bit about our history and background.

The Camden County Medical Society has not only the distinction of being one of the oldest Medical Societies in the United States, but it is the elder, by 1 year, of the American Medical Association. This Society first convened at Haddonfield, and later made its headquarters at the old hotel at Cooper and Front Streets, in Camden. For 85 years, our Society has exerted an influence in shaping medical legislation and in defining the medical policy of the State of New Jersey. It has watched over and preserved the public health; it has advanced methods of medical practice; elevated the standard of medical education; strengthened the reputation of the County in knowledge and character and public spirit; and has contributed in innumerable ways to the common good of both County and State. It is a cause for our personal gratitude that this Society has played so commendable a part in the social uplift of our fellow men.

I have chosen as the subject of my Presidential Address—As the Doctor Sees His Profession.

From an individual point of view nothing else is so indispensable, or of such inestimable value, as the element of enthusiasm for one's work. Such an attitude puts one in touch with the higher things in life. The physician who contemplates the human body and mind and finds no wonder in them, no stimulus to his imagination, nothing to excite an enthusiastic response; class him with that tourist who found nothing more in the glorious Alps than—"A lot of mountains and that sort of thing." Well, it may be a long way between the glory of a mountain prospect and the consideration of a doctor's profession, but when viewed in the light of lasting worth and enjoyment, it is all the

same, for without an enthusiastic interest in things they always appear drab, colorless and insignificant. What we need, then, is to put into our profession all the zeal and spirit that we possibly can. We ought to feel that it is the grandest and finest work in life and that we will determine to make some contribution to it not only for the personal satisfaction of having done so, but for the good it will do for the social welfare of our fellow men.

The character of a doctor's work is such that he cannot permit himself to be outmoded. *Keeping up-to-date*—That may sound like a banality, but for all of its commonplaceness, it is one of the sign-posts which every doctor must not only note but heed. Beginning with Pasteur's chemical and biologic revelations, and the ever-increasing multiplicity of advanced theories in the fields of science, it becomes well nigh an impossibility for most of us, who find it necessary to make our profession a means of livelihood, to keep conspicuously abreast of all the varied contributions being made every year. Nevertheless, there is a degree of natural and practical absorption toward which we must strive. The character of our reading and reflection will determine largely the extent of our profit. Let it not be even frivolously said of any one of us, that he has not cracked a book since he left college. For all thinking people, Lafayette epitomized the proper attitude of mind toward serious subjects, when he said: "I read, I study, I examine, I listen, I reflect, and out of all this I try to form an idea into which I put as much common sense as I can." For the most part, I feel that our profession manifests a more intelligent fervency in acquiring the knowledge and skill necessary for the successful performance of its work than is found in many other vocations. There was a time when a physician's influence was fostered by superstition and ignorance. Today his success and efficiency depend upon his ability to apply the latest acquisitions of science.

With each succeeding generation the profession calls for the finest type of men—men of understanding and sympathy. With the many problems involved in social relationship, the psychology which determines the trend of the day, the natural sciences which are conducting the investigating mind into the great complex science of modern medicine, with its emphasis upon preventive medicine and public health; it is absolutely necessary that the doctor be a man with common sense and understanding.

This leads me to consideration of the position which a physician should command in the community. No man deserves recognition who does not evidence the qualities of mind and character which are worthy of appreciation and acknowledgment. In our profession one must of necessity possess the type of mind characterized by intellectual acumen and penetrating foresight; and, of equal importance, is a character that wins the respect and confidence of others. Today, more than ever before, it is indispensable that a patient should have the utmost confidence in his physician. Considering our work from this high plane it lays upon us grave responsibility and we are constrained to believe that no man liveth unto himself. Happy are we if we possess these qualities.

In some measure, I am confident that we have qualified ourselves to take a position of prominence in the community. By the years of scientific and cultural pursuit, by fidelity to the standards of morals, by virtue of the service we have rendered to the public, we have brought ourselves to a position deserving of the respect and acknowledgment of the people.

However, there is another side to this; for, if by virtue of our profession we have gained the recognition of the public, with that there goes a still greater sense of responsibility. There is the increasing realization of a larger custodianship of the public health placed in our keeping. We cannot under this realization confine our interests simply to those who seek our advice. Aware, as we are, of the continued injury that is being perpetrated upon the credulous and unsuspecting, by those who have neither by the gift of nature, nor the credentials of the schools, nor civic authority, the right to minister to the afflictions of the human body, it is a blot upon the escutcheon of our profession that such practices

continue and so little is being accomplished in eradicating this evil. We are neglecting our duty when by any indifference we permit continuation of the quack and charlatan. These persons are enemies to all true scientific progress. What though there may be found in their ranks, here and there, one who is well meaning enough! Good intentions have already filled too many graves, and maimed too many lives. But the gravity of the situation lies in the fact that the great majority are outspoken impostors and their number is legion. It is not simply cowardice, but more often the lack of constructive planning, that encourages this harmful practice which goes unchecked before our very eyes. To tear down existing evils without supplementing wholesome remedies will not suffice. To cry out against news-papers carrying fraudulent medical advertisement upholding quacks, will avail nothing unless by a definite program we consolidate our energies and present a united front against these practices.

Something constructive ought to be projected in order to check this unsavory condition. I would suggest that our Society should make definite arrangements for a systematic and regular order of information to be given to the public through the agency of the press. This may be a departure from the usual method of medical advertising, nevertheless it is a legitimate and highly respectable one. A space several columns wide advertising the Camden County Medical Society, with its proper seal and identification, containing the names of all doctors in good and regular repute in the Society, in conjunction with the instruction—"In case of sickness call one of these doctors for advice and treatment." It is time that the directory of physicians should be lifted out of the back of the telephone book and put squarely before the public. The advantage of such a project is easily seen. It gives the doctor recognition and denotes official standing as a practitioner of medicine or surgery. It also indirectly creates in the public mind a confidence in the doctor as to his qualifications to treat the sick. I submit these brief suggestions in the hope that something will be done in this respect.

It is most interesting to watch the excellent policy of the Philadelphia Medical Society as it goes from one advance to another. Here we see in a respectable and dignified manner the virtues of the profession brought to the notice of the public by means of the radio, auditorium address, films, and department store window display. We would do well to take a cue from a sister Society. We are glad, however, to recognize the evidence of progress in our own state. The Post-Graduate Extension Work has been received with steadily increasing interest, which has placed the Medical Society of New Jersey in conspicuous leadership in educating its members in up-to-date scientific medicine.

Permit me to call your attention to another matter which, because of its very character, is commanding the thought of many doctors. I refer to Group Practice Medicine. We are rapidly approaching a condition in society when the physician will be hampered in his professional life by political maneuvers and manipulations. Many outstanding medical writers see in some form of Group Medicine the best defense against such political enactments as would destroy the normal and reasonable practice of the physician. Advances in medical knowledge have made it impossible for any one man to know and care for all phases of illness. The general practitioner and the specialist must work hand in hand. The constant daily personal contact which group effort insures does much to stimulate the individual doctor and to keep him abreast with medical progress. With laboratory aids at one's elbow, and someone with special knowledge of his problem in a room across the hall, the doctor is in a position to give his patient sound advice backed by the resources of the group. All of which leads us to believe that Group Medicine increases efficiency, promotes economies and affords protection against State Medicine. A paper on Group Medicine and State Medicine would be an interesting sub-

ject for the Society to discuss in the near future.

I would like to suggest further, that we make ourselves sufficiently important as a society, to command the attention of the civic authorities, so that before any health measures are advanced we will be consulted and together prepare such improvements as will benefit the public health.

We are happy to see the spirit of coöperation between our homeopathic friends and ourselves, which has resulted in a mutual regard and appreciation for each other's contribution in our common task. The scientific committees of both societies have done good work this year in presenting our home talent for our enlightenment and enjoyment. The closer our fraternal contacts, the more frequent our meeting together, the less will be our misunderstandings and the greater will be our appreciation for each other's virtues and abilities. Let us cultivate these social graces.

And now, gentlemen, as we have together been looking through the eyes of a physician upon his peculiar work, does it not appear to be a very grand and noble calling? Upon an old English cottage, just outside the door, there hung a large sign which has been called the "Six All". On it there were portrayed 6 representative characters with an appropriate inscription under each, as follows: "The King, I Rule All; The Priest, I Pray for All; The Soldier, I Fight for All; The Lawyer, I Plead for All; The Working Man, I Pay for All; The Doctor, I Cure All." That should be the passion of our profession, not simply its perfunctory function.

It has been a real pleasure to have occupied this year the office of the Presidency of this Society. The duties attached to it, I have tried faithfully to perform. Whatever has been achieved was made possible by your coöperation, and I have greatly enjoyed working with you. As our new President takes office for the following year, may he have from you, as he shall for my part, the same kindly consideration and support you have given me.

VINCENT'S ANGINA*

H. V. Hubbard, M.D.,
Plainfield, N. J.

One year ago, when you gave to me the honor of serving as President of the Union County Medical Society, it was with deep appreciation of the great responsibilities and confidence which were therein bestowed that I assumed the duties of this office. Now that it has passed, I am sure that a year is all too short a time for one not formerly active in and familiar with the details of the Society work, to acquaint himself with traditions and carry on in the creditable manner which the Society so justly deserves. However, I am sure we have had a prosperous year, even in the midst of the greatest general depression the world has ever known. Our activity in State affairs has progressed with interest and our regular Society meetings have been well attended and interesting, for which all credit is due to the committees arranging them and to each and every member who has participated. I wish to thank all the officers, committees and members for the interest they have shown, for only by the coöperation of individuals can the officers of any group be successful.

I wish now to recommend the reëstablishment of the Post-Graduate Medical Courses during the coming season for the benefit of all physicians in this County and I regret that such courses were not organized last year, but on account of my being away at the time when they should have been started such action could not be taken until it had become too late.

For the remaining brief time which I shall occupy this stage I would like to review some of the chief points of interest in, together with some personal experiences of, the disease called Vincent's angina—Ulceromembranous laryngitis, or Vincent's laryngitis.

Vincent's angina, first discovered by Vincent, and until 1914 regarded as a rare dis-

*(Presidential Address to Union County Medical Society, Oct. 13, 1932.)

ease, was seen quite frequently among the soldiers during the early part of the World War. In units having a dental surgeon attached, the disease was found much less frequently, which tends to show that attention to mouth conditions, especially of the teeth and tonsils, is a valuable aid in prophylaxis. In fact, I think it can truthfully be said that the disease is never seen in an otherwise clean and healthy mouth. It is well known that the mouth can be and frequently is the most foul, containing the most diversified varieties of bacteria, of any cavity in the body, and is no doubt the starting point of not only this disease but a majority of the diseases which the human body is heir to.

Etiology. Associated with uncleanliness in the mouth, is the presence of a fusiform bacillus and a spirochete, which are anaërobic—a characteristic not to be forgotten when treatment is being considered. These organisms are easily seen through a microscope but will not grow on any of the ordinary media, and are hard to culture; special media and means being necessary.

This disease is most frequently found in the pharynx, tonsils and around the teeth in adults, but may, rarely, be found in children with chronic otitis media, most often between 2 and 12 years of age, and is not so very infrequently seen in the parenchyma of the lung. In short, the soil in which this infection develops is as much a factor in development of the disease as the specific germ itself.

In text-books issued as recently at 1929, like the one edited by Chevalier Jackson and George Morris Coates, there seems still to have been no definite course of progress determined which the disease follows. Herbert S. Burkett, of Montreal, under the name Vincent's Angina, describes a course of mildly inflammatory type, ulcerative in character, principally around the teeth and in the tonsils. E. J. Moure, of Bordeaux, France, in the same book, describes what he calls ulceromembranous laryngitis, or Vincent's laryngitis, as a very acute disease, with marked swelling and inflammatory characteristics, extending from the mouth to the pharynx, larynx, trachea, and even to the parenchyma of the lung.

All describe the same specific laboratory findings—fusiform bacillus and spirochetes predominating—but considering the onset and progress of the disease different authors relate 2 more or less distinct courses or trains of symptoms.

Type 1. The mild, and more nearly pure, Vincent's organism type may begin with a simple gingivitis and pyorrhea, lasting for weeks, months and even years. The gums ulcerate away and pus containing almost pure Vincent's organisms may be found by means of smears under the microscope. Such cases are seen and successfully treated almost daily by physicians and dentists, and if proper cleanliness and use of antiseptics, together with removal of such teeth as cannot be cleaned, is carried out, the condition goes no further. All patients with pyorrhea should be examined microscopically by means of smears and cultures, to determine the character of the disease and proper means of treatment.

It seems to me that the day has come when no physician or dentist has a right to say to his patient, "Yes, your teeth, tonsils, sinuses, gall-bladder or appendix, are infected but not enough to cause your iritis, arthritis, myocarditis or what not", but should in all cases set about cleaning up all sources of infection.

If *this* disease is allowed to spread to the tonsils and pharyngeal region, the throat becomes moderately sore, necrotic tissue covered with a grayish-white, pulpy-looking exudate appears, and deep, crater-like ulcers with a foul odor develop in the tonsil. These ulcers often progress for several weeks before any treatment can stop them. Similar ulcers may occur in the larynx, on the vocal cords, in the trachea, and in parenchyma of the lungs. This type does not develop swelling or edema of the larynx, but the location and depth of the ulcers, at times, cause much concern. Yet, even with all this, there is comparatively little general systemic disturbance, and the temperature seldom rises above 100° F. The submaxillary lymph glands become enlarged, but not particularly tender if the tonsil only is involved. This type does not markedly incapacitate the patient, or keep him from his labors or regular duties.

Type 2. The more acutely inflammatory

type of Vincent's angina also develops from foulness and infection of the mouth and teeth. It reveals itself first in redness of the pharynx, followed by sore throat and hoarseness, and this process rapidly spreads to the larynx and upper respiratory tract until, within 3 or 4 days, it has produced an edema of the larynx, even to the point of asphyxia and necessity for tracheotomy. Swallowing is, at times, difficult and painful; profuse purulent expectoration and erosions develop, and we find ourselves dealing with a grave, systemic infection, which may involve even viscera such as the liver, kidneys or central nervous system.

The microörganisms, fusiform bacilli and spirilla in the acute inflammatory type are usually mixed with staphylococci and streptococci.

Vincent's disease must be differentiated from several others which are somewhat alike in ulcerating appearance; principally cancer, diphtheria, tuberculosis and tertiary syphilis. The laboratory findings are of the utmost importance, but there are also other means of differentiation.

Diphtheria. Membranous patches show no cupping, but do show Klebs-Loeffler bacilli; as against deep cupping and destruction of tissue, and Vincent's organisms present.

Cancer. Not only is the general systemic condition characteristic, but the edges of the ulcers are hard and indurated, as are the tissues and glands nearby, and a biopsy will usually reveal the diagnosis.

Tuberculosis. The history, general condition and presence of tubercle bacilli in other parts of the body are indicative, and the ulcers are not so rapidly destructive.

Syphilis. To the unskilled eye, the ulcerations often appear much the same as in Vincent's disease, but the history and laboratory findings, not forgetting the Wassermann reaction, will be of great diagnostic value.

Treatment. Just as varied, protracted and perplexing as the course of this disease has been the treatment thus far prescribed. The "right thing at the right time" is of great value, and by the action of certain drugs in certain cases we may be led to believe that a certain drug will prove to be the *cure all,* but our very next patient may reveal the fact that the supposedly *right* remedy has little or no effect.

Case Reports

Case 1. A. W., a strong young man of 18, traveling about but complaining of a mildly sore throat for a month. Large ulcerating patches were seen on the left tonsil and postfaucial pillar. He had been treated by other physicians but without benefit. Laboratory findings showed Vincent's. Besides local treatment to the ulcerating areas he was given 2 doses of neosalvarsan and 1 dose of the old salvarsan, at intervals of 4-5 days, with no improvement. I have no doubt that he sensed my dismay and went to another physician who, in spite of the absence of Klebs-Loeffler bacilli, gave him a dose of diphtheria antitoxin; following which he promptly and completely recovered.

Case 2. G. J., a stout man of 50 years, came in complaining of having had a sore throat for 3 weeks. One large, deep ulcer covered the right tonsil area, having eaten away the entire tonsil. The laboratory reported Vincent's and no Klebs-Loeffler. Two doses, 0.6 gm. each, of neosalvarsan were given intravenously, and salvarsan in glycerin was applied locally, together with application of 2% copper sulphate solution to the ulcers. None of these had the slightest effect. A dose of 15,000 units of diphtheria antitoxin, given in spite of the presence of Vincent's and absence of Klebs-Loeffler organisms, started his recovery. Washes of peroxide of hydrogen, and application of sodium perborate paste to the ulcers, completed the recovery.

Case 3. Acute inflammatory type: Miss H., a slender young lady about 20 years of age, to whom I was called in consultation, was very acutely ill, with moderately high temperature, large ulcerating patches on the tonsils and pharyngeal wall, tremendously sore throat, and was in short suffering from an acute general infectious disease. Repeated laboratory tests showed unmistakable Vincent's. One dose of 0.6 gm. neosalvarsan was given. The next day there was perceptible improvement, which continued, and after one more dose of

neosalvarsan complete recovery followed, without any other active treatment.

Treatment. Some of the best known remedies for local use are peroxide of hydrogen and sodium perborate, on account of their high oxygen content and the anaërobic character of the bacteria. The peroxide should be used as a mouth wash and gargle, and the perborate as a paste applied directly to the ulcer area. Copper sulphate, 1 or 2% solution, or chromic acid solution 2%, applied by means of cotton applicators several times daily, are of great value in some cases. It has been my experience that the usual antiseptics, such as phenol, iodine, boric acid, etc., have no value whatsoever. Intravenous use of arsphenamine, either the old or the newer forms, is of great value in many instances. Other patients, not benefited by this form of treatment, are cured by the use of diphtheria antitoxin injected subcutaneously. I believe the benefit of antitoxin results from the reaction produced by its foreign protein content. At present I know of no satisfactory way of selecting the drug best adapted to the given patient. It seems, therefore, that in case a certain remedy is not producing the desired results, too long a time should not be wasted before other remedies of reputed value be substituted.

PRIMARY CARCINOMA OF THE LUNG IN A 14-YEAR-OLD BOY

Robert A. Kilduffe, M.D.,
Director of Laboratories, Atlantic City Hospital,
and
Samuel L. Salasin, M.D.,
Visiting Physician, Atlantic City Hospital,
Atlantic City, N. J.

Within recent years interest in the occurrence and recognition of primary carcinoma of the lung has greatly increased, and the consequent enrichment of the literature has greatly clarified our conceptions of this hitherto infrequently recognized disease.

The comprehensive discussions of the subject by Weller and Fried render unnecessary any further general survey in this place.

The purpose of this communication is to record the occurrence of a primary carcinoma of the lung in a boy aged 14 years.

All available authorities are in accord in regarding the age incidence of pulmonary carcinoma as comparable to that of cancer in other organs. However, occasional instances have been reported of its occurrence in rather young individuals, or in other words, in those below the usual "cancer age". Fried, for example, reports a case encountered by himself in the decade between 20-30 years and refers to reports of others at the ages of 17 years (Weller), 18 years (Fishberg), and 1, reported by Steffer and Hirsh, in a boy aged 5 years.

While the occurrence of carcinoma of the lung below the age of 20 has thus already been noted, it seems sufficiently infrequent to warrant the following story.

Case report. T. W., a white boy, aged 14, was referred to the Atlantic City Hospital by Dr. Clyde M. Fish and admitted June 25, 1931, to the Medical Service of Dr. S. L. Salasin.

On admission, the chief complaints were marked dyspnea, headache, cough, and pain and stiffness in the right side. The family history, later obtained by Dr. Fish, revealed nothing of interest relating to the grandparents. The mother was tuberculous, and one sister succumbed to the same disease. The patient's birth was normal, without instrumentation, and followed a normal pregnancy.

His past medical history showed measles when 6 years of age, followed by a recurring bronchitis during winter months. During the past 3 months he had suffered from numerous "colds" but there had been no other illnesses and no record of injury. While said to be a willing worker, in the past 6 years he had made only 2 grades at school. The history of his present illness was as follows:

About 3 weeks before admission he developed a severe cold with alternating periods of recovery and recurring cough. While at school—but never while at home or during the night—he had occasional attacks of vomiting. The cough then became rather constant and

was associated with relatively constant dyspnea when he came to the hospital.

Physical examination on admission showed a well-developed boy, rather large for his age, with a somewhat peculiar color suggesting *bronzing,* of which, however, it was not typical.

The chest was particularly broad and full in appearance and attracted attention, also, because of evident dilatation of the superficial veins which were seen on the neck and abdomen. The head, neck, eyes, ears, nose and throat, presented no findings of interest.

On percussion of the chest, there was evident consolidation of the upper and anterior portions of both lungs to the level of the nipple, the remainder of the lungs showing no abnormalities. In this area of dulness the breath sounds were distant but no râles were heard. The heart was normal both on percussion and auscultation; abdomen, extremities, and genito-urinary system presented nothing of interest; temperature, 100°; pulse 122; respirations 56; urinalysis showed no abnormalities. Blood examination: Hb. 8.69 gm.% (Hayden) or 63% (calculated); R. B. C. 3,800,000; C. I. 0.8; differential count (100 cells): polys., 59; small lymph, 40; eosin., 1; no abnormalities evident in the stained blood smear. Kolmer, Wassermann and Kline precipitation tests were negative.

A second blood count 4 days after admission showed 84% polymorphonuclear neutrophiles as the only significant change.

The report of an x-ray picture of the chest on admission was as follows (Dr. Westcott):

"Examination shows a large, non-pulsating mass in the right chest extending down to the diaphragm, with an area on the left side extending from the third to the sixth interspace in the axillary line, which probably represents a pressure atelectasis. The heart shadow is completely obscured. The general appearance is not that of a mediastinal effusion, and the most probable diagnosis is lymphoblastoma."

From June 25 to July 1, 1931, the patient exhibited an irregular temperature ranging from 102° with a pulse of 160, to subnormal levels (97°); the lowest pulse rate being 90. During this period the respirations varied from 45-60.

During his entire stay in the hospital he had a rather persistent and, at times, severe cough and also at times complained of pains in the chest. At no time was there any expectoration.

On June 23, while attempting to drink a glass of water, he had a severe attack of dyspnea, leading eventually to cyanosis so marked and extreme as to require artificial respiration and the administration of oxygen. The attack lasted about 20 minutes, a perceptible cyanosis persisting for nearly an hour.

On July 1, the condition having remained in general unchanged, his parents signed a release and took the patient home. After 2 weeks at home, the dyspnea becoming more marked and continuous, it was decided to return him to the hospital, but on July 15, while being driven to the hospital in an automobile, he complained of a choking sensation and died suddenly without evidence of pain or cyanosis.

Autopsy report. The body is that of a well-developed white male aged 14 years, showing a moderate degree of rigor. The skin has a somewhat cyanotic color; lower extremities show a moderate degree of emaciation; definitely contrasting with a well-marked symmetric anterior prominence of the thorax, in which region there is definite distension of the superficial veins.

Thorax. Some difficulty was experienced in removing the chest plate because of adhesions of the underlying organs. The greater part of the thoracic cavity is filled by a large, symmetric tumor mass which has compressed the upper lobes of both lungs and displaced the heart downward and backward. The mass surrounds and is adherent to the trachea, main stem bronchi, and esophagus. The lymph nodes in this region are enlarged and firm.

The tumor mass cuts with ease and on section is fairly firm and of a yellowish-gray color. The cut surface shows mottling with dark-grayish pigment, and grossly resembles a section through a lung showing gray hepatization and pneumonoconiosis.

The pleural cavities are filled with clear, straw-colored fluid, and pleural membranes

are somewhat thickened, grayish-yellow in color, and adherent to the tumor mass. The upper lobe of the lungs, on each side, has been forced into the posterior thorax by pressure of the advancing tumor mass and appears to be atelectatic. This is more marked on the left side in which, in addition to an extensive inflammatory reaction, there is a well-marked and fairly extensive area of necrosis.

The remainder of both lungs presents a compensatory emphysema and a moderate degree of edema; no evidence of tuberculosis. The general appearance of the left upper lobe is that of abscess formation and a septic pneumonia.

The heart is of normal size and, except for its displaced position, presents no gross findings of interest.

Abdomen. The spleen is moderately enlarged but otherwise normal, and the abdominal viscera present no gross abnormalities.

The lungs and tumor mass were removed *en masse* and dissected only with great difficulty.

Whereas the first impression was of a tumor originating in the mediastinum and, perhaps, invading the lung, on dissection it become apparent that the reverse was true; namely, that the mediastinal involvement was secondary to a pulmonary neoplasm which had started in the left lung and invaded the mediastinum by extension along lymphatics and infiltration of contiguous structures. This impression was confirmed by histologic examination.

Histologic report. Sections were cut from various portions of the tumor mass and the lung, including areas which appeared to be contiguous if not continuous. Paraffin sections were prepared after formalin fixation and stained with hematoxylin and eosin. Microscopically the picture was similar in all the areas examined, varying only in grade. In structure the tumor showed a variety of aspects but, after some study, evidently began in the lung as an alveolar carcinoma. As it invaded the mediastinum, there was some attempt to reproduce the original histologic structure but this was soon lost and the sections show a confused and heterogeneous composition in which are found irregular, formless masses of epithelial cells, islands of lymphoid tissue showing inflammatory reaction and epithelial invasion, occasional areas of hemorrhage, inflammatory reaction, and necrosis, and, occasionally, small amounts of fibrous tissue.

Sections through lung areas show extensive necrosis, hemorrhage, and inflammatory changes marked by definite plugging of the bronchioles and alveoli by inflammatory exudate.

The histologic diagnosis was: Carcinoma of the lung with mediastinal invasion; pulmonary abscess and septic pneumonia.

PROSPECT

(An appeal to the New Year—1933, by
E. S. Corson, M.D., Bridgeton, N. J.)

Swing wide the door, fling ope' the gate,
  Throw out the things that brought us woe.
Forget the sting of passing pain,
  Let care and sorrow onward go.

Bring in the flame of fellowship,
  And kindle smothered fires anew;
Make drooping eye and wrinkled face
  Aglow like sunshine lights the dew.

Fill in the void of fortunes lost,
  With friendship rarer far indeed.
Then humble homes will peaceful prove,
  And crusted loaf meet hunger's need.

Make thrift restore the fortunes lost,
  And faith fare forth with high resolve.
Make plans for castles high in air,
  With rock-ribbed base naught can involve

Let fact efface suspected view,
  More kindly judge our brother man,
Forgive we can; forget we may,
  Restore what's took and usury ban.

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

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All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent to THE CHAIRMAN OF THE PUBLICATION COMMITTEE (address above), Newark, N. J.

A NECESSITY FOR RENEWING THE ANTIDIPHTHERIA CAMPAIGN

In our Lighthouse Observations for the Journal of September 1932, attention was directed to the final report on the State-Wide Antidiphtheria Campaign, and to the fact that the Committee which had for 5 years so satisfactorily conducted that campaign announced the conclusion of its work, feeling, as its Chairman explained, that it had accomplished all that was required or expected of it, and hoping that the County Campaign Committees, which had been set up with such special care, would continue their activities until diphtheria should have been driven completely out of New Jersey. So well had the state committee, with the assistance of the local groups, performed its functions, that the desired goal seemed to be within easy reach; for it appeared that protection against this dread disease had been given to practically our entire state population except those youngest citizens covered by the term "pre-school-age children"—meaning those below the age of 6 years.

Throughout the entire period of its existence, the state committee had been careful to guard the interests of the family physician in the matter of immunizing those who could pay, in full or in part, for such health protection service; and, the immunizing of children under 6 years of age was considered to be especially and peculiarly a thing to be kept within the province of the family doctor.

It was realized, of course, that withdrawal of the stimulating influence exerted by the state committee might be followed by a laxity of function on the part of local committees, despite the fact that the county committees had been carefully selected and, in part, for the specific purpose of placing the single remaining task in the hands of and under the control of the family physicians. Our fears and our hopes were, indeed, intermingled in the following statement: "There is no sound reason why diphtheria may not be eradicated from a state—especially with the conditions now existing. New Jersey can, and should, be the *first* state to accomplish that feat. In fact—and let us not lose sight of this—*if it be not accomplished,* at least approximately, in New Jersey during the next 2 or 3 years, *the blame* for such failure *will fall* more heavily *upon the medical profession* than upon any other group of citizens—*and justly so.*"

Thus, the situation in September. At the Conference of County Society Secretaries and Reporters on November 2, 1932, we gave expression to our feelings—that what we had feared *might happen,* actually *was happening*—and said we had observed certain indications that we were *slipping backward* in the matter of diphtheria prevention; that the records showed a diminishing number of immunizations monthly; and that, contrariwise, the morbidity and mortality rates were again showing progressively higher figures.

It is becoming apparent now that New Jer-

sey is about to repeat the experience of New York City, where, according to a report issued by its Health Officer, Dr. Shirley W. Wynne, what had been gained by an extensive and intensive campaign has been steadily dwindling and is in danger of being completely dissipated. Within the month we have been asked by our State Board of Health, at Trenton, whether it is possible to induce our local committees to resume the fight and make one more strenuous effort to eradicate diphtheria from our state? That question, of itself, confirms our suspicions and justifies our fears.

What can we do? Well, our local—county and town—committees can, if they will, resume their tasks as may be necessary in their respective territories. Then, let each family physician scan his own list of families in which there are children who should be immunized, and advise their parents that this is a particularly favorable time to have such things done—while the doctor, less busy than in normal times, has an abundance of time to devote to such details of practice as immunization requires. There is nothing unethical in advising the mothers among your cliéntèle to have their children immunized; in practicing preventive medicine, it becomes the family doctor's privilege and duty—both.

OUTSIDE OPINIONS ON THE REPORT FROM THE COMMITTEE ON THE COSTS OF MEDICAL CARE

Among lay periodicals, the 2 most widely read are, we suppose, the Saturday Evening Post and the Ladies Home Journal, and from the latest issues of each we quote from editorials, as follows:

The Saturday Evening Post of Feb. 4, 1933, says: "Despite the marvelous advances in medical science and the recognized devotion and skill of so many of its practitioners, the prevailing method of purchasing medical care has some unsatisfactory consequences. It often leads to unwise, wasteful, inadequate and undirected expenditures, and often to inequable remuneration of practitioners.

Even the *minority report,* with all its vigorous opposition to mass production, tacitly admits that everything is not well with the present system. It admits the evil of charging separately for each visit and for different parts of the service in chronic disease, and recommends a system of inclusive fees for definite periods of time. It suggests, also, experimenting with the County-Medical-Society plan of providing complete medical care.

The layman who reads these reports is sure to be puzzled by the conflicting viewpoints, even though couched in non-technical language. But the reports are well worth assembling, if only to stimulate discussion. Medical costs must be met, and they can be met with less suffering than at present. Most European countries have developed organized systems of medical care. They may not have proceeded with the greatest wisdom, but *they have acted.* It is neither necessary nor wise to develop socialistic medical systems in this country. But, by concerted and carefully planned efforts, the existing facilities can be used with less waste and hardship than now."

"It is the opinion of the Ladies Home Journal (February) that the accomplishments of this 5-year study are to be measured by the *minority report* and not by that of the *majority* with its Utopian and impractical schemes; that the family doctor is the most-efficient and least-expensive source of general health; that state medicine, with its demand for compulsory insurance and increased taxation, is in every way to be avoided; that the mass production of health, through any medical hierarchy or bureaucracy, is impossible; and that the simple health-insurance plan presented last month in the Journal in Paul de Kruif's article, 'How Well Can We Live?', is so far the most practical of all methods to enable our people to pay for illness.

We have politics messing its often-dirty hands in business, in our schools, in most public affairs and some private ones as well. But may we be preserved from politics in personal health."

Special Article

THE SPECIALISM PLAN*

John F. Hagerty, M.D.,
Newark, N. J.

Opposition to the "Specialism Plan", as expressed at meetings in Jersey City and Newark, would seem to indicate that the medical profession in those districts is not yet prepared to coöperate with the State Society in its desire to lead in this progressive movement, and it is possible that any change in established methods suggested at this particular time would meet with a similar reception. The business depression which is affecting everybody adversely, the Report of the Committee on the Costs of Medical Care, and locally unsatisfactory conditions prevailing in some places, have made this an inopportune time to ask for action upon new propositions, and such conditions must be considered in judging the attitude of the profession toward this question. It must be said also that the advocates of the plan were not given an opportunity to answer the arguments advanced by the opposition; many of them not justified by anything contained in the plan. I am, therefore, asking permission to publish the reasons for advocacy of this measure by the State Society, as read at the above mentioned meetings, with comments on some of the statements made by its opponents.

First of all, arise the questions—why should there be *specialists,* and why should our State Society be interested in that subject? In presenting the following arguments, may I ask you to remember that, while reflecting my own views in the matter perfectly, none of them is original with me, but all have been abstracted from various articles on the subject and represent the conclusions of those who have given much serious thought to the problems involved. There is nothing new about *specialism;* indeed, it is as old as medicine itself, for Herodotus in 500 B. C. said that: "The art of medicine is divided among them; each physician applying himself to one disease only and not more."

Specialism is necessary in our own times for several reasons, such as: "The growth of knowledge has been so rapid that time has not permitted the individual physician to form a critical judgment of the value of some of the newer methods." * * * "Knowledge has been increasing so rapidly that no single individual can master the entire field, and an inevitable division of labor has resulted in the development of many forms of specialism." * * * And, again "Specialism is necessary because of the limits of receptivity of the human mind. No man could hope to be a universal diagnostician." And, to those quotations I might add, that the same is true as to a universal therapeutist, using that word in the broadest sense.

You all know that there is no law in any of our states designed to prevent anybody from *putting himself forward as a specialist.* You know also that the right to practice a specialty in these United States *may be assumed by any one* who has secured the degree of Doctor of Medicine (M.D.) and a state's license to practice general medicine—a term that is *all-inclusive.* Those statements are true, but, it is also perfectly well known to all of you that these *rights and privileges have been abused,* and that such abusive actions have resulted in criticism of the profession by the public, and in lessening that high regard for the profession which the public formerly held.

Now, I wish to repeat the statement that—*any licensed physician may hold himself out as a specialist,* and in any particular line; and to add that he can and may, *while practicing a specialty continue in general practice*—and no organization has any right or power to interfere in the slightest degree with his lawful pursuit of either or both general practice and special practice. I have emphasized this because some persons have found fault with the "Plan" because it does not restrict specialists and hold them to their chosen, special class of work; while, at the same time others were finding fault because of their belief that an attempt was being made to prevent specializa-

*(An Address delivered at the Annual Meeting of the county societies comprising the First Councilor District of the Medical Society of New Jersey, Jan. 12, 1933.)

tion. I might say here, too, that the choice of the word—*control*—was an unfortunate one, having, to some, a sinister meaning. It follows, from what I have explained, as to rights and privileges, that such things could not be done; and I assure you that there was no such wish on the part of the State Society, nor of anybody associated with development of the plan.

In an article recently published in our Journal, Dr. E. J. Marsh, of Paterson, said: "Specialism should be the legitimate and reasoned outcome of the growth of knowledge. No rational person objects to specialists. The necessity for them is too obvious. It is against the excessive development of this plan of practice—the exuberant granulations, so to speak—that criticism is directed, both lay and professional."

The Board of Trustees of the American Medical Association says: "We recognize the need of specialists and esteem the man who is a real specialist."

The Report of the Committee on Medical Education, recently published, and which, by the way, is a very splendid report, says: "Specialism is an essential part of modern practice. It is recognized, however, that many specialists are self-named. Many are not fully trained in their limited field, and are still less well equipped in the fundamentals of medicine. *Some are frankly commercial.* The medical profession and the public have a joint responsibility in guaranteeing that those who claim special knowledge are, in part, experts in their fields. A particular *identification should be created for qualified specialists,* such recognition to be granted only upon evidence of special study, courses of training, and ability. * * * The most important qualifications for the practice of medicine are: character, native ability, industry, training and experience. These qualifications can be best judged by a faculty under whom the individual has studied (or by a group which has had the opportunity of observing the individual at his work), and every State should keep a register from which the public could learn which specialists have had suitable preparation." This last-quoted sentence is just what the State Society, in approving Dr. Waters' plan, proposed to do; and it should be a matter of pride that your own Society was the first to adopt such a plan.

Practically the same conclusions have been published in the Report of the Committee on the Costs of Medical Care. Referring to a section of that Report, the New England Journal of Medicine, the local official mouthpiece of several New England States, says: "It is a responsibility of the medical profession to guarantee to the public that those who claim to be specialists are, in fact, experts in their fields."

One of the best arguments for consideration of this problem by the medical profession is contained in the temperate and thoughtful statement of Dr. W. Harvey Smith, a recent (1930) President of the Canadian Medical Society: "When under authority a license to practice is granted, it simply indicates that the individual to whom it is issued has at least the minimum qualifications of a general practitioner. It does not certify that he possesses special knowledge in any of the many divisions of medicine. He may be a man of the highest character and ideals, willing to place the welfare of his patient first, and to avoid operations and procedures which he has neither the capacity nor the experience to perform. This is true of the majority of practitioners. On the other hand, he may be of a type, not unknown, that pretends to knowledge not possessed and qualifications non-existent. I would like to stress the urgent need of securing, in Canada at least, such amendments to the Provincial Acts as would enable the governing bodies of our profession to pass upon the qualifications of men purporting to be specialists."

Now, Mr. Chairman and fellow practitioners, I have endeavored to show you by the opinions quoted—not by statements of my own—that the question of specialism is one deserving of your consideration, and that *the State Society had not only the right but the duty* to set up plans which would enable the people in this State to know who, among its members, are qualified to hold themselves out as specialists; and thus to save the profession from criticism and loss of public esteem.

Dr. Follansbee, Chairman of the Judicial Council of the American Medical Association, and one of the signers of the Minority Report of the Committee on the Costs of Medical Care, says, speaking of specialism: "The public is fully aware of the unsatisfactory conditions existing today, and unless the medical profession itself corrects these conditions, the State will attempt to solve the problem."

Dr. Reik in an address before the Delaware State Medical Society said: "A point of great importance to us at the moment is that recent complaints are not directed at specialism and the increasing number of specialists so much as they are an indictment of the profession for not providing the people with some means of identifying competent specialists."

The American Medical Association, through the Council of Medical Education, is now certifying specialists in anesthesia, pathology, and roentgenology—and publishing their names in the Journal.

Dr. John Hartwell, when President of the New York Academy of Medicine, proposed a plan to regulate specialism by dividing the existing membership into Members and Fellows, the latter group to comprise those who desire the distinction and can qualify as specialists in any branch of medicine or surgery. An examining committee was to be named from among those members whose standing as specialists is above questioning, and the hope was expressed that the plan would be adopted by the New York State Medical Society.

So that, to repeat, there was sufficient justification and warrant for our own State Society devoting its time and thought to this subject. In addition, just a short time ago an Act was introduced into our State Legislature which, if enacted into law, would have caused severe and unjustifiable hardships to a large proportion of our profession in New Jersey. This measure, while happily defeated, and defeated a second and third time through the efforts of our State Society, emphasized the need of action, and, very opportunely and fortunately, the present Plan, with some slight differences, was presented by Dr. Waters, who, by the way, is entitled to great credit for conceiving the Plan and for whatever benefits may result from its operation. I shall leave to Dr. Waters and others explanation of the Plan, but will ask permission for a few moments longer to justify what I said in the beginning—that misunderstanding accounts for much of the present opposition.

It is doubtless well known to most of you that the Plan was presented recently to the Hudson County Medical Society and, it must be admitted, was not accorded a very flattering reception, but, let me quote you some of the objections presented at that meeting, many of which could not have been better expressed as arguments in support of the Plan.

Dr. C. "What we do need is not to accredit specialists but to discredit those men who claim to be specialists and are not."

Dr. R. "This plan won't prevent any man from labeling himself a specialist."

Dr. K. "To my mind the person that is best qualified to judge the standing of the specialist is the general practitioner—the one who comes in contact with the specialist, who observes his work and results, who has full confidence in him and transmits that confidence to the patient." No better argument for the Plan could be asked.

Dr. K. "There is one point to be considered in any law—that no law, rule or regulation is any stronger than the power of enforcement, and unless some law is put into effect that will punish the man who hasn't a certificate, it is not going to do any good. The non-specialist can call himself any kind of specialist and get away with it." This was all well understood by the Society and the danger of legal complications was purposely avoided. Further, public opinion and professional endorsement and good will are often more powerful than the law.

Dr. Woodward, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, in a letter referring to the Plan written to Dr. Maras, and quoted by him, said: "The plan you submit is entirely extra-legal. It does not affect the legal rights of any licentiate to designate himself a specialist, whether or not he holds the certificate provided for in the plan. * * * If he desires such a certificate he may make application. If he does not desire it, as I read the

plan, he may, nevertheless, designate himself a specialist, without leave or hindrance." This letter of Dr. Woodward might well be read again. It emphasizes the avoidance of legal entanglements and the fact that the plan does not interfere in any way with the *legal rights* of any regularly licensed practitioner, be he specialist or not. Application for endorsement is purely voluntary.

I hesitate to take too much of your time. The plan in detail will be discussed by Dr. Waters and others, but I wish to emphasize the fact that this plan was conceived with the best of motives, having in mind counteracting harmful criticism, preventing outside interference with medical affairs, raising the standing of the profession, and fulfilling the mission of the State Society in its relation to the public. Not the slightest thought was in the minds of the sponsors of offending the honorable, thoroughly qualified specialists to be found in every city in this state. It was hoped that, should these physicians receive the endorsement of the State Society, others might be encouraged to follow their example, and thus many of the reasons for criticism and ridicule would be eliminated.

This, in brief, is the purpose of this plan. Realizing the force of good example, it was felt that endorsing the well-qualified, outstanding specialists throughout the state would have an educational value, which might stimulate others to emulate their example. What has prompted so many in this state and throughout the country to aspire to Fellowship in the American College of Surgeons and Physicians, which after all is a very impersonal honor? The desire to be well thought of by one's brother practitioners. There was no thought of preventing specialism, or of creating specialists, since the profession is powerless to do either.

There are, unfortunately, one or two features of the Plan, not affecting the purpose, which have proved unsatisfactory, but which can be easily changed. The County Society Committee, which the sponsors thought would appeal strongly to members, as being fair and impartial, has been objected to, and, I assure you this Committee could be dispensed with and the State Society Committee, as at present constituted, would suffice. The matter of *charging a fee for endorsement* received a great deal of thought, and, as was feared, has been objected to, though when I remind you that 285 physicians in this state are paying $500 each to the American College of Surgeons for a *Fellowship,* it hardly seems fair that the fee asked for endorsement by the State Society should be objected to so strongly. And, when it is further considered that these *Fellows* will pay eventually $142,500, the statement that there are 1400 physicians in this state eligible for endorsement, who would bring in to the State Society $35,000, loses much of its force, even if correct, and that it is correct, is to be seriously doubted.

In conclusion, Mr. Chairman, *I sincerely hope that this Plan,* which has been under consideration for 2 years, and which has been approved by the Board of Trustees and the Welfare Committee of the State Society and adopted by the House of Delegates of the Society in open meeting, *will not be cast aside.* An earnest effort has been made to acquaint the profession with the reasons for advocacy of the Plan, without giving any offense. References to unprofessional conduct, with which all are familiar, were purposely avoided. However, we were greatly surprised at the sarcastic allusions to the words "honorable, ethical and moral", and to the imputation contained in the recital of the passage from Scripture. An answer to the question: "Are we not all Doctors and are we not all honorable, ethical and moral?" had already been given by the guest speaker of the evening, Dr. Van Etten, who said: "The profession ought to get after the cheap, *unreliable specialists* who are in a large measure responsible for the investigation into the Costs of Medical Care", and who denounced "the disreputable racketeers in New York and Brooklyn, who, through Workmen's Compensation service, are undermining the profession of New York State."

Whether the Plan proves acceptable or not, those responsible for its introduction will have the satisfaction of knowing that they tried to do constructive, helpful work for the medical profession in New Jersey.

Medical Ethics

IS A MAN TO SPEND HIS LIFE SAVING HIS OWN SKIN?

John Hammond Bradshaw, M.D., F.A.C.S.,
Orange, N. J.

Our title is not taken from a text of Billy Sunday. Neither is this intended to be a sermon. It is some satisfaction to string off a line of ethical platitudes, for it gives one a "holier than thou" sort of feeling. This is, however, far from the intent of the writer.

After years of taking the assorted knocks that this world gives, it is a poor sort of mentality that does not come to the time when a man realizes his "place in the sun" and his true limitations.

Now our skin, we are obliged to admit, is one of our most valuable assets. If one does not look carefully after one's own immediate belongings, it will not be long before they belong to somebody else.

The phrase "saving one's skin" goes back many years for its origin. It was even used in frontier days. Not only the men but the beasts of the wilderness had to spend much of their lives in efforts to retain their skins. When nailed to a barn door or a tree, it was, furthermore, not of much use to its original owner.

We must admit that we live in a selfish world. The great majority have little chance, or even desire, to look after others (those not belonging to their immediate family). Grinding necessity, if not want, is now the average lot. When a Peabody, a Carnegie, or a Rockefeller appears, he stands out like a mountain peak upon a level plain of monetary mediocrity—and even poverty. Let it be now remembered that most of the great benefactors of their fellow-men today would never have been in the financial position to work their benefactions if, in their early days, they had not carefully (if not too carefully) looked after their own skins.

The *good book* tells us that "if we save our life we lose it, and if we lose it we save it". From our last few years' experience, we have found out the little fact that—if we save our money we shall also lose that! If this applies to sordid cash, why should it not apply also to one's immortal soul?

Now, by the word *skin,* we do not refer only to our epidermis; yet if we expect to live in this "vale of tears" any length of time, it is up to ourselves alone—nobody else—not only to protect our skin but all that it covers. As before stated, doctors are themselves careless about this. Why not now go to that good friend of yours and have that long deferred periodic examination?

In Lighter Vein

They'll Bear Watching

Mrs. A.—"I like to have a man about, don't you?"

Mrs. B.—"Provided I know what he is about."—Boston Transcript.

Popular Moratorium

We were only mildly interested in reading that Prussia has abolished billboards. The kind of enlightened statesmanship we'd get a kick out of would be one that abolished boardbills.—Boston Herald.

Making an Island Homelike

Author—"I've got a good tale here about a man and 2 women on a desert island."

Editor—"Good heavens, man, that plot's as old as the hills."

Author—"Not this one—these women are his wife and his wife's mother!"—Philadelphia Star.

After You, My Dear Gaston!

A customer sent the following note to his grocer: "Please send 6 dozen eggs; if good, I will send check."

The grocer, however, was not doing any business on such risky terms, so he replied: "Send check; if good, I will send 6 dozen eggs."—Montreal Star.

Why Not Aaron?

The circus was doing badly and funds sank lower and lower. At last the cashier pinned up a notice announcing that in future salaries would be paid as funds permitted, and the artists would be paid in the alphabetical order of names.

Next day Zero, the strong man, called on the cashier.

"I have come," he said, "to tell you that I have changed my name."

"Oh!" replied the cashier. "And what are you going to call yourself now?"

"Achilles."—Tit-Bits.

Magic Discovery

Jack—"This liniment makes my arm smart."

Joan—"Why not rub some on your head?"—Answers.

Big Round-Up

"I understand your wife came from a fine old family."

"'Came' is hardly the word—she brought it with her."—Laughs.

Little Pitchers Have Loose Ears

Teacher—"Who can give me a sentence containing the word insulate?"

Small Boy—"At the breakfast table ma said to pa: 'How come you got insulate?'"—Buffalo Evening News.

Current Events

WELFARE COMMITTEE MEETINGS

January Meeting

The Welfare Committee, meeting at the Hotel Stacy-Trent, Trenton, on January 8, at 2 p. m., was called to order by the Chairman, Dr. Charles H. Schlichter. Roll call disclosed the following named members present: Berkow, Clayton, J. G. Coleman, Costello, Dandois, Davis, Donohoe, Green, Hagerty, Lee, Lippincott, Londrigan, McMahon, Meigh, Morrison, Morrow, Mulford, North, Schauffler, Schlichter, Sewall, Sherman, Tracy, Ely, Newcomb, McGuire and Mahaffey; telegrams and letters of excuse for absence were received from Drs. Conaway, Haussling, Larkey, McBride, Sommer and Ulmer.

Report of the Executive Secretary

January 8, 1933

Our report today is a brief one, consisting in the main of an explanation of the delay in publication of the January Journal; though we can say now that its printing will be completed in a few days and we hope to have it in the mail for distribution by January 15. The routine was being followed, and with the exception of County Society reports, all material for the regular monthly issue was in the hands of the printer—most of it in type—by December 15, when we were suddenly confronted with a new problem. You have all heard, I suppose, that when the final Report of the Committee on the Costs of Medical Care was made public—November 29, 1932—we seized upon it as a timely topic for consideration by the Tristate Medical Conference scheduled for December 10. We had as Guest Contributors to that Conference: Dr. T. C. Routley, Secretary of the Canadian Medical Association, to speak on "National Health Insurance in Great Britain, with Special Reference to England and Canada"; Dr. John A. Hartwell, of New York, to analyze the above mentioned Report; Dr. A. C. Morgan. an Ex-President of the Pennsylvania Medical Society, as one of the *Minority Report* signers, to explain the Committee division; and Dr. R. G. Leland, Chief of the Bureau of Economics of the American Medical Association, to open the discussion upon these papers and an additional one presented by the Editor.

It seemed to us worth while to disrupt, temporarily, our publication plans in order to *provide all of our members with a fair amount of information concerning the 2 Reports—Majority* and *Minority*—of the Committee on Costs of Medical Care. Happily, as you also know, we anticipated the action taken on December 18 by the Board of Trustees.

Of course, we knew that the complete Report was soon to be available in book form at $1.60 each, but we had no means of ascertaining how many members would purchase the book, however desirable it might be that each should know its contents. The Society could scarcely afford to supply copies to all members, because, at the price named that would have cost $4500, and even had we been allowed a discount as high as 50%, the cost would still have been out of reach. Looking for some means of putting that Report into the hands of each and every member, it dawned upon us that the Journal could be used as a medium of transmission, and without any additional cost to anybody except the Editor, to whom the amount of labor required became the important problem; but he felt that could be managed.

We could have utilized the *abstract* sent out by the American Medical Association, but it did not furnish sufficient information to enable one not previously concerned with the Committee's work to form his own deductions and conclusions. So, we set out to make a more liberal abstract, and that proved to be a larger task than we had anticipated. The Report is, in itself, an abstract of the study made during 5 years. We have succeeded, however, in further condensing those 200 pages into about 40 pages of the Journal.

The Editor feels now that but for his many years of experience in that kind of work he could not have accomplished this task satisfactorily. Abstracting is an art. We have done our best with a difficult job, and can only hope the result will meet with your approval.

To our own abstract, we have added, in the January Journal, a complete report of the recent Tristate Conference, and we have also included a list of reference books for those who may wish to delve more deeply into the story of state medicine. With the exception of 6 Original Articles and an Editorial, all January Journal space has been devoted to supplying our members with a comprehensive statement of this important economic problem.

This plan caused the postponement, necessarily, of other material we should have liked to present in the January issue but such delay will, we hope, be compensated for by the value of the Report. County Society reports can be doubled-up in February, and otherwise nothing much will be lost.

Respectfully submitted,

Henry O. Reik, M.D.,
Editor & Executive Secretary

Upon motion of Dr. Londrigan, seconded by other members, the Executive Secretary's report was received and approved.

Dr. Londrigan presented a report for the subcommittee on Expert Testimony, including the draft of an amendment to the existing law which would authorize the Court's appointment, in its judgment, of an independent witness or witnesses to testify in an independent and unprejudiced manner, without interference with the legal rights of either party to a suit employing their own experts, at any trial. This amendment, being the one prepared several years ago by representatives of the State Medical Society and State Bar Association, was approved and the hope expressed that the Bar Association might coöperate in procuring its enactment.

Dr. North, in the absence of Dr. Sommer, presented the report for the Sub-Committee on Conference with Representatives of the Osteopathic Society, as follows:

After several conferences with the Sub-Committee of the Welfare Committee of the State Medical Society, it was decided that the Committee representing the Osteopathic Society should submit, in writing, the general results of the meetings.

Proposition Submitted by the Osteopaths

We submit, as concretely as possible, the conclusions arrived at between these 2 committees. The Osteopathic Committee would like to introduce, in the coming Legislature, a Bill embracing the following ideas, and would like the approval of the Welfare Committee for the proposed Bill:

(1) Write a new section into the Osteopathic

Law—establishing machinery for the State Board of Medical Examiners to issue a license in *"Osteopathy and Surgery"*.

(2) All graduates in osteopathy and surgery, after the passage of this Act, shall, in addition to 4 years' high school and 4 years in an approved osteopathic school, present evidence satisfactory to the Board that he or she has had 3 years of additional training, at least 1 year of which has been a post-graduate year. The remaining 2 years may be post-graduate in a hospital or college approved by the Board, or may be preliminary college work toward an A.B. degree before entering osteopathic college. This brings the requirements for *"Ostcopathy and Surgery"* up to 7 years and provides for the intern year. It permits the sixth and seventh year, however, to be either pre- or post-graduate work. This section might be regarded as a flexible section.

(3) The preceding flexible section might remain in force for the period of 5 years. After January 1, 1939, the preliminary educational requirements shall be exactly the same as those required of medical students, and the intern year shall be practically the same, allowing it to be spent in any hospital or post-graduate school approved by the Board.

(4) Osteopathic physicians who, at the time of the passage of this Act, hold a license to practice osteopathy in New Jersey, shall be eligible for a license *to practice Ostcopathy and Surgery* by: (a) presenting credentials satisfactory to the Board, that he or she has been an ethical and reputable licensed practitioner of osteopathy for at least 5 years; (b) credentials showing a full year of post-graduate study in operative surgery; (c) pass an examination in materia medica, therapeutics and surgery.

(5) In lieu of 5 years of practice, the candidate licensed in *ostcopathy* may qualify for the broader license by showing: (a) 2 full years of post-graduate study in a college or hospital approved by the Board; and, (b) by passing an examination in materia medica, therapeutics and surgery.

(6) Allow the present Osteopathic Act to remain, except to broaden the definition of osteopathy to meet that of New York, which is the same as medicine and surgery, except that—"A license to practice osteopathy shall not permit the holder thereof to administer drugs or perform surgery with the use of instruments." Allow future graduates for a period of 5 years to qualify under the present Act as *osteopaths* and permit them to quality later for the broader license under the same requirements as in (4) and (5) preceding.

(7) Amend the present Osteopathic Act in one further particular; i.e., the enforcement of the Act—Put it in the hands of the Attorney General instead of, as at present, in the hands of the "County Prosecutor".

These changes will permit the present osteopath to continue his present type of practice and at the same time to qualify for the broader license, if desired, by submitting further qualifications. It would require future osteopaths and surgeons to meet the same minimum requirements as a doctor of medicine. The Osteopathic Society is sincere in its desire to raise the requirements to equal those of regular medicine, homeopathic medicine and eclectic medicine. If it does this, it feels that it should be given the same privileges as other schools. At the same time, we ask very serious consideration on the part of the Welfare Committee, and hope that action may be taken so that the proper legislation may be introduced this year.

General Discussion

A lengthy discussion followed, in which the following members participated: Drs. Morrison, Mulford, Costello, Coleman, McGuire, Hagerty, Lee, Newcomb, Sewall, Ely, Davis.

Upon motion of Dr. Costello, it was voted unanimously that this Welfare Committee is opposed to admission to the practice of medicine and surgery of anybody who has not fulfilled the requirements of the present Medical Practice Act of New Jersey.

Dr. North was requested to convey that message to the Osteopathic Delegates awaiting in another room in the hotel.

Dr. Berkow presented the following resolution, which was unanimously adopted, and the Executive Secretary was instructed to forward a copy thereof to the Honorable A. Harry Moore, Governor of New Jersey:

"Resolved, That the Welfare Committee of the Medical Society of the State of New Jersey, expresses its satisfaction with the appointment of Dr. J. V. Smith, of Perth Amboy, by Governor A. Harry Moore, to the Board of Control of the State Department of Institutions and Agencies. Dr. Smith's personality, integrity and professional experience, both in the conduct of his own extensive practice and in relation to organized medicine, through this State Society and the Middlesex County Medical Society, eminently qualify him for the work of the Board to which he has been appointed."

Dr. Newcomb presented 3 documents consisting of proposed amendments to existing state laws: (1) An Act requiring that applicants for admission to State Normal Schools should be required to present medical certificates showing that they had received a thorough medical examination, including especially an x-ray picture of the chest, showing that there did not exist any evidence of tuberculosis or other infectious disease; (2) required a similar examination of school teachers, and further provided for the dismissal of any teacher employed by the state whose radiograph showed the existence of any tuberculous lesion or other infectious disease; (3) was a proposed law authorizing school physicians to strip children above the waistline for physical examination, when deemed necessary in making physical examinations.

After considerable discussion, in which objections were made particularly to the *drastic character* of the first 2 amendments; and to the *necessity* for the third, considering the discussion of that point at the School Physicians' Section of the State Medical Society; the Bills were returned to Dr. Newcomb for further consideration and revision.

Dr. Coleman moved the appointment of a committee to confer with Dr. Newcomb regarding these Bills and to report at the next meeting of the Welfare Committee, and his motion was adopted.

The Chairman: I will appoint upon that committee Drs. Mahaffey, North and McGuire.

Dr. Mahaffey announced that the Princeton Commission had included in its report to the Governor a recommendation that the State Health Department should receive all that it had asked for this year, including an appropriation of $39,000 to cover the cost of publication of its Bulletin called Health News, and the cost of the District Health Officers heretofore provided for but not fully covered financially in the budget of last year.

Dr. McGuire announced that the Princeton Commission had not treated the Board of Medical Examiners so generously, but had, instead, he understood, recommended the amalgamation of the Board of which he is Secretary, and the several other Boards of similar character, into a Bureau and on a plan similar to the provisions carried in the Abell Commission report of 1931. He stated that the Bar Association and the Association of Real Estate Brokers were the only Boards exempted from this consolidation procedure.

Upon motion of Dr. Londrigan, the committee voted to take the same stand in regard to this recommendation as it did in relation to the Abell Bills.

The meeting then adjourned.

Henry O. Reik, M.D.,
Executive Secretary

EXECUTIVE SECRETARY'S REPORT to the WELFARE COMMITTEE MEETING OF DEC. 18, 1932

(This report was submitted to the Welfare Committee on December 18, 1932, but was not published in the January Journal, along with the *proceedings* of that Committee—see page 120—because the space was more urgently needed for other matters.—Ed.)

Almost half of the State Medical Society's fiscal year, commencing with the close of the Annual Meeting of 1932, has already passed. The second quarter, embracing the months of October, November and December, has been, in our office, an extremely busy period. Between sessions of the old and the new Welfare Committee, we have "carried on" as well as possible; and we beg leave to prseent you now with a report of our activities during that period.

(1) *Centenary of British Medical Association*: In our Annual Report to the House of Delegates, you were apprized of the fact that we had been selected and appointed by Dr. Edward H. Cary, President of the American Medical Association, as 1 of the 3 official Delegates asked to represent the medical profession of these United States, at the Centenary of the British Medical Association, to be held in London, July 24-30, 1932. You will recall, also, that this State Medical Society added to our honors, in response to a suggestion from President Hagerty, by requesting and authorizing us to present to the British Medical Association the compliments and felicitations of the oldest medical society of this country—which was then engaged in celebrating the 166th anniversary of its founding. Some time soon we will prepare (as promised editorially in the December Journal) a detailed report of our participation in that event, and record some of our observations which seem to us applicable to our own organization plans and works.

(2) *Meeting Legislation Half-Way*. That—"This is a small world" is one of those axiomatic expressions frequently heard and not infrequently demonstrated, was borne out by a recent experience. During the month of September, while vacationing in Switzerland, we saw one morning in a Paris edition of the New York Herald, a statement to the effect that Governor Moore, of New Jersey, had requested Princeton University to select from its Faculty (preferably among those teaching or doing research work in the field of economics), a Commission to make an investigation and study of the existing form of state government, with particular regard to efficiency and cost, and to report to the Governor, before the end of this calendar year, such criticisms and recommendations for improvement as might seem desirable. The newspaper story proceeded with a listing of the several departments and various subjects to be included in the investigation but without *any reference whatsoever* to public health or to the practice of medicine as connected therewith. Indeed, the absence of such references was so noticeable as to make us suspicious, especially upon recalling to mind a certain group of Bills introduced during the General Assembly of 1932 at the request of the Governor. To refresh our memories of those Bills, let us recall these facts:

In the campaign of 1931, the state budget was one of the most important topics of discussion. Governor Moore's victory was based, in some measure surely, upon his promises to conduct an economic administration. It is said that he gave much thought to such matters during the interval between election and inauguration, and he caused to be introduced during the General Assembly of 1932 a series of Acts for the redemption of his promises. We were much embarrassed by having to oppose Governor Moore's plans for re-organizing the state's business methods. It seemed to place us in that group of citizens which indulges freely in destructive criticism, but never offers anything constructive. However, we felt that the Governor's offerings would not effect his stated purpose.

You will remember that one of those Bills proposed abolition of the State Board of Health and the substitution of a Department of Health whose Chief should be a member of the Governor's Cabinet, which was to be established; and another Bill proposed to place the State Board of Medical Examiners, and all boards of similar character, in a Bureau to be set up in the Department of Education, but which provided no adequate personnel in that Bureau to perform the highly specialized tasks of the present Board.

The Governor drove us to join the opposition because of 2 mistakes which he made: (1) that he, or his advisers, had not sufficiently well investigated existing conditions in regard to health matters; and (2), that he had not sufficiently considered the probable consequences of the proposed legislation. Through the medium of letters, private conferences, and appearances before the Legislature's committees holding public hearings, we, working along with others, managed to make clear the facts which had been thus overlooked, and the Bills were defeated.

Now, this past September, reading of the appointment of the Princeton Commission, we said to ourself: "Again, it is the same old story; every other topic will be investigated and studied, and if another profession be involved its members will be asked into conference to discuss possible legislation. But public health problems will be given only a casual glance, the medical profession will not be consulted, and the first knowledge of impending changes to reach us will come when a budget of proposed legislation appears at Trenton."

Immediately upon our return home we consulted Dr. Schauffler, and it was through his courteous intervention that we received an invitation to confer with the Chairman of the Commission, Professor Dodds, at Princeton. We soon learned that our early suspicions were justified. The Commission was, in a mild way, investigating the medical field; its members were tolerably well informed

concerning health matters, through the reading of published reports. Some of them had visited the State Board of Health; a smaller number had seen the inside of some institutions; and, a report upon existing conditions was in process of preparation. But, there had been no consultation with physicians outside of those institutions, or as an organization, and, apparently, no such consultation was scheduled.

We sought an interview; were most graciously received; ascertained the length and breadth of the study; proposed a conference with a small, special sub-committee from the Welfare Committee; and secured the appointment of such a committee, consisting of Drs. Lippincott, McBride and Green. Later, Drs. Morrison, Mahaffey, McGuire, English, Levy, Pollak, Morrow and Knight, and Mr. MacDonald, were brought into another conference with the Commission. As a result, an agreement was reached which seems satisfactory to everybody because it was based upon frank discussion and perfect understanding.

At the Nassau Club Conference, the whole field of public health work was covered and, in consequence thereof, we have reason to believe; (1) That the Commission's Report will *not* propose any legislation inimical to the interests of this Society; but (2) may make some recommendations that will strengthen our position with regard to our medical public relations. For instance, we were asked if we would like to have the legal requirement of submitting to the appointing power one or more names of physicians from which list District Health Officers should be chosen for appointment—as with the State Board of Medical Examiners—and, further, an extension of similar powers to County Medical Societies with reference to Local Health Officers. We are hoping the Commission will make such recommendations.

(3) *Annual Conference of County Society Secretaries and Reporters.* This year's Conference was held in Trenton on Wednesday, November 2, 1932, and was fairly well attended. The main topic of discussion was the inauguration of the Waters plan for certification of specialists among our own members. Ex-President Hagerty, in charge of that task by special authorization of the House of Delegates, described the procedure and asked for cooperation of the Secretaries. The complete proceedings of that Conference appear on page 166 of this Journal.

(4) *Tristate Medical Conference.* The National Committee on Costs of Medical Care, having completed its investigation, conducted over a period of 5 years, made public its final report, at the Academy of Medicine in New York, on November 29. It developed then that the Committee, consisting of 48 members, of whom 24 were physicians, had been unable to agree on all points, and, in consequence, there was a definite split and 2 reports: a *majority* report signed by 36 members, of whom 16 were physicians; and, a *minority* report, signed by 8 members, all of whom were physicians.

We had been entrusted with an advance copy of these reports, in full, under secrecy, of course, prior to the release date, of November 29. Incidentally, we may report that we have been kept informed during the entire period of 5 years, through advance copies of reports (28 in number) on topics under investigation, and have all of those reports in our office files.

On November 25, we received from A. M. A. headquarters in Chicago, under like conditions regarding release, an abstract of the Committee's Reports, and an advance copy of Dr. Fishbein's editorial as it appeared in the A. M. A. Journal of December 3.

We were due to hold a Tristate Conference on December 10 and the above mentioned Committee Report naturally became *the* important topic for consideration at that Conference. The subject of National Health Insurance (often called *State Medicine*) is, very naturally, allied to the Committee Report. As we had made certain observations on the working of that form of insurance in Great Britain and France, 2 years ago, and had another opportunity to study the situation while attending the Centenary of the British Medical Association, and as we had met in London the Secretary of the Canadian Medical Association and noted the fact that he was an unusually well-informed member of the profession, we made the Conference program to open with an address by the said Secretary, Dr. Routley; to follow with a report of our observations; and then we were fortunate enough to secure for the program Dr. John A. Hartwell, of New York, and Dr. Arthur C. Morgan, of Philadelphia, as a member of the Committee, to analyze the *Majority* and *Minority* Reports. It was perhaps the most important Conference we have yet held, and this was probably the first responsible and capable group of medical men to give formal serious consideration to those Reports. We are publishing the entire proceedings of that Conference in the January issue of your Journal, and we respectfully request that each member of this Committee shall spread the news through his county that the January Journal will be, in large measure, devoted to *Economics* and each member should read it promptly and carefully because this topic is likely to be under consideration and up for discussion at many medical meetings during the next year. We are supplying the fundamental facts for enlightenment of those among our members who have not the time to read the entire Reports, and possibly have not access to the reports of discussions taking place in other states.

(5) *Standing and Special Committees.* We have done our best since the first of October to stimulate and to render aid to those engaged in the following projects: (a) Antidiphtheria Campaign; (b) Maternal Welfare Committee; (c) Post-Graduate Instruction; (d) setting up the School Physicians' Program formulated by Dr. Ireland; (e) program for the State Society's Annual Meeting in June next; (f) recommendation of work for the Woman's Auxiliary; (g) assistance to the Committee on Certification of Specialists.

(6) *Field Secretary.* Our Field Secretary, Mrs. E. C. Taneyhill, developed, during the summer, an excellent working program and prepared new addresses to be added to the list heretofore offered to various organizations. From every place where she has lectured this year—several of them being organizations covered in previous years—we have received *the most flattering reports of her work,* and her services are in demand considerably beyond possibility of fulfilling.

(7) *National Legislation.* It is doubtful if any one can at the present moment predict what subjects will be brought into consideration during the remaining time of the lame duck Congress, but there are 1 or 2 matters which should receive serious consideration.

Most important of all is that problem concerned with post-War legislation. You are all familiar with the outrageous legislation already enacted with reference to medical care and hospitaliza-

tion, pensions and bonuses, to alleged Veterans of the World War. You know, perhaps, that existing laws are making a terrific drain upon the National Treasury and that a group of Veterans, aided and abetted, if not controlled and directed by outsiders whose policies are inimical to good government, are actively engaged in the demand for additional legislation of similar character. We trust that some action will be taken upon that question today, not merely by the passing of resolutions, but, possibly by the appointment of a special sub-committee to oppose further legislation in that direction and to demand repeal of some of the present laws.

(8) *Local Legislation.* We are informed that the osteopaths have in mind the introduction of an amendment to the existing law designed to extend their privileges. President Lippincott appointed a sub-committee, of which Ex-President Sommer is Chairman, to confer with the Committee on Osteopathy regarding that matter, and we assume that Dr. Sommer will make some report today.

We are in receipt of a communication from Dr. B. T. Beasley, of Atlanta, Georgia, sent evidently to other State Societies, requesting endorsement of a series of resolutions which, after stating that the medical profession is suffering from the financial depression and that the production of additional graduates of medicine is in excess of the population increase, demand that the medical colleges of the United States adopt a policy of reducing the number of graduates in medicine annually until the law of supply and demand has been complied with.

In the report of a meeting of the Executive Committee of the New Jersey Tuberculosis League, held on December 7, we note that there was a lively discussion concerning the x-ray and tuberculin testing of school children, and particularly as to the question of whether this is proper work for school physicians or tuberculosis clinics, and we respectfully suggest the appointment of a sub-committee to confer with the Tuberculosis League or its officers regarding these matters.

We have submitted to Dr. Londrigan, who holds over as Chairman of the Committee on Hospital and Physicians' Bills as Liens upon Damages Awarded to Patients, a report of legislation enacted in other states, and he will doubtless report as to whether this is a favorable opportunity to request an amendment to the New Jersey law on that subject.

The State Association of Social Workers held a meeting recently. It is, you may recall, the organization formed to carry on the plans set up by the Hoover Conference on Child Health and Welfare at Washington and the Larson Conference held last year in New Brunswick. Upon receipt of a letter, asking whether we thought the program, preliminary copy of which had been issued, might be of interest to physicians, we had occasion to direct attention to the address delivered by your Executive Secretary after having been approved by Dr. Sommer, then President of the State Society, and Secretary Morrison, in which was set forth what this Society considers the proper relationship of physicians to public health and welfare work conducted under the Aegis of lay organizations. The answer received promptly disclaimed any intentional offense to the Society and we hope it will prevent recurrence of such situations in the future.

(9) *The Journal.* It speaks for itself. The only change in prospect is the probability that we shall make the January issue very largely one concerned with economics, and we ask the forbearance of those members whose articles, communications or reports may have to be side-tracked for a month in order to accomplish this; and we particularly ask that the news be widely spread that the January Journal will present an exceptional publication of information relating to the Costs of Medical Care and the consideration of National Health Insurance offered by the profession in the hope of preventing adverse legislation.

ANNUAL CONFERENCE OF COUNTY SOCIETY SECRETARIES AND REPORTERS

Held at Trenton, Nov. 2, 1932

The conference convened at the Carteret Club in Trenton, November 2, 1932, and was called to order at 12 o'clock noon by its President, Dr. D. F. Featherston, of Asbury Park, who said: "Like the success of all good organizations, the success of this conference depends to a great extent on its Secretary, and I want to say that our Secretary has been faithful and worked hard, and to him will credit be due for whatever success this conference may attain."

The guests in attendance were: Drs. A. H. Lippincott, of Camden, President of the Medical Society of New Jersey; Allen G. Ireland, Medical Director State Department of Public Instruction, Trenton; W. G. Schauffler, Princeton, and John F. Hagerty, of Newark, Ex-Presidents of the State Society; J. B. Morrison, Newark, Secretary, and Henry O. Reik, Atlantic City, Executive Secretary of the State Society; Dr. Scammell, of Trenton, Councillor of the Second District; J. Lynn Mahaffey, Director State Board of Health.

Roll call showed the presence of the following County Society representatives:

Atlantic: John Irvin, Reporter, Atlantic City. Bergen: S. T. Snedecor, Secretary, Hackensack. Burlington: George T. Tracy, Secretary, Beverly; and R. I. Downs, Reporter, Riverside. Camden: R. S. Gamon, Secretary, Camden; and Vincent Del Duca, Reporter, Camden. Cumberland: E. C. Lyon, Secretary, Bridgeton; and E. S. Corson, Reporter, Bridgeton. Essex: Frank W. Pinneo, Secretary, Newark; and E. Le Roy Wood, Reporter, Newark. Gloucester: Henry B. Diverty, Reporter, Woodbury. Hudson: B. T. D. Schwarz, Secretary, Jersey City. Hunterdon: Barclay Stokes Fuhrmann, Secretary-Reporter, Flemington. Mercer: A. D. Hutchinson, Secretary-Reporter, Trenton. Middlesex: Samuel Berkow, Secretary-Reporter, Perth Amboy. Monmouth: D. F. Featherston, Secretary, Asbury Park; and H. A. Kazmann, Reporter, Long Branch. Morris: A. J. Ward, Secretary, Morristown. Ocean: Alfred Woodhouse, Secretary, Toms River; and Eugene E. Herbener, Reporter, Lakewood. Somerset: A. F. W. Sferra, Secretary, Bound Brook. Sussex: F. P. Wilbur, Secretary, Franklin Furnace; and F. H. Morrison, Reporter, Newton. Union: G. W. H. Horre, Secretary, Elizabeth.

Motion was made that the Minutes of the 1931 meeting, as already published in the Journal, be adopted; which motion was seconded and declared carried.

President Featherston stated that the first 2 speakers listed on the program had not yet arrived and he would call upon the Executive Secretary of the State Society for any remarks he

might care to make concerning county society work.

Some State Society Affairs Requiring County Society Development Presented by the Executive Secretary

Dr. H. O. Reik: I am pleased to accept the privilege of directing attention to some things the State Society hopes to have done during the course of this fiscal year.

(1) *Specialism.* The first item, one of considerable importance, is the development of Dr. Waters' plan for *guidance of specialism.* I have used that word *guidance* as a substitute for the word *control,* as heretofore attached to the plan, because I have heard that in some counties that word has aroused fear that somebody is trying to secure undue control over our members practicing as specialists. The plan is conceived primarily to care for a situation which was becoming dangerous. For 3 successive years there appeared in the Legislature a bill entitled—"An Act to Control the Practice of Surgery and the Surgical Specialties". I will not discuss this topic further because Ex-President Hagerty is here to tell you about his plans for setting up this scheme and starting it on its proper course. It is left for me to say about it, at present, only that you may dispel such fear as exists, and help put this plan in operation.

(2) *School Physicians.* The second topic is that of the School Physicians' Program which was adopted at the Annual Meeting in June. We are saying editorially in the November Journal that we have, for the first time, a definite and clear-cut program for school physicians. And, furthermore, Dr. Ireland has, in that program, very clearly and definitely drawn the dividing line between the school physician and the family physician, showing where the work of the one starts and ends and the work of the other begins. The whole program, as adopted at the State Society meeting, appears in the November Journal, and we hope that Dr. Ireland will be here a little later this afternoon to make a personal explanation of some features of that plan.

(3) *Post-Graduate Courses.* The next topic is that of the Post-Graduate Medical Courses conducted by our State Medical Society and Rutgers University. Dr. Cosgrove and his associates continue their excellent work but there has had to be a modification of the general arrangements this year because the appropriation of funds from the State to the University was cut markedly by the last General Assembly and Rutgers is not able to do for us all that it did last year. In consequence, the local committees will have to supply places of meeting for these lectures; pay for janitor service for use of such hall or room in a hospital, or wherever the lectures may be delivered; provide a lantern, if required, to illustrate the lecture, and a lantern operator as needed. If the University can be relieved of such expenses, it can take care of other features of the work as conducted heretofore, and will avoid having to increase the fee.

This "joint committee", appointed from Rutgers University and the State Medical Society, under the chairmanship of Dr. Cosgrove, has done, as most of you know, a remarkable piece of work. There is, indeed, something quite unique in this method of post-graduate instruction. The committee is getting the best available teachers, and during the past 2 years has been having those lectures delivered, practically, on the front doorstep of the family doctor. That is something which has not been accomplished in any other state and we trust that you will continue to give your support to the committtce which is doing such fine work. The first of the courses for this season started last night at Skillman, where, through cooperation of the Somerset County Society and Dr. Renner with the State Society-Rutgers University Committee, they have developed a Special Course in Neurology. In view of the financial circumstances, they have promised to give as much in a course of 6 lectures as had heretofore been covered in 8 lectures, so that the conservation of time will in some measure offset the slight increase of cost to which we referred.

(4) *Group Insurance.* If you will look up your "Transactions", published as a supplement to the September Journal, you will find a number of very interesting reports presented at the last Annual Meeting, not the least of those being the several reports dealing with group insurance of various kinds. One wants to be particularly careful in times like these when doing surgical work, and be sure that he is protected from malpractice suits. It is an opportune way for some people to secure money and I think we may expect an increased number of suits during this and the next few years. It would be well for you secretaries to advise your county society members to look after this by taking advantage of that particular insurance feature—the defense and indemnity policy—and to look over the other types of insurance offered for your benefit by the committee which is headed by Dr. Pinneo—namely, the health and accident policies, and the automobile insurance.

(5) *Workman's Compensation.* Regarding the work of special committees, there is one thing that Ex-President Sommer has remained deeply interested in, and that is correcting conditions in the Workman's Compensation Law. Dr. Sommer has spent a great deal of time, and worked very hard, over this matter and is still carrying it along. Any of you who have complaints to make, or suggestions to offer in the line of improvement, should take advantage of the existence of this Committee and communicate with Dr. Sommer. If it is more convenient to communicate with Dr. Morrison, remember that he is a member of the Advisory Board to the Commissioner of Labor.

(6) *Maternal Welfare.* In Dr. Hagerty's régime a Special Committee on Maternal Welfare was set up, with Dr. Bingham as its Chairman. A local committee in Essex County, under his Chairmanship, had done remarkably good work and it is hoped that they may be able to extend their plans throughout the state. In each county there has been, or should be, appointed a special committee to coöperate locally with Dr. Bingham. Further details of the plan will be presented to you by him, at proper times as the work of these local committees develops. Give him all the assistance that you possibly can, because it is considered by some to be a disgrace to the medical profession that the maternal mortality and the infant mortalilty rates stand as high as at present in this country.

(7) *Diphtheria Immunization.* Some time ago we gave you notification of the closing of the work, in so far as the State-wide Committee was concerned, of the Antidiphtheria Campaign. In the September number of the Journal, department of Lighthouse Observations, you will find a lengthy report of what has been accomplished by that committee; of the closing of this work; and of its being truned over to the 21 county

local subcommittees that had been formed during the active part of the campaign. The reason for turning that over to the local committees was first, that the same people who had been guiding the active campaign should be in control of the situation; secondly, that control by the profession might be retained, because those committees had been very carefully selected; and finally, because the sole remaining problem at the time the State Committee closed its books was that of dealing with the pre-school child. That work is in the province of the family physician. I fear that the same thing is happening here that happened in New York, for a statement published but a few days ago said that "the campaign which was carried on so successfully up until 2 years ago has been adrift since and there is already noticeable a climbing rate of diphtheria mortality". Now, we had the school children pretty well cared for, and this State was pretty thoroughly immunized down to that point, but if we neglect the really most important factor—the preschool child—we shall soon have similar evidence of being adrift. So, it will be appreciated by the State Society officers if you will revive or resuscitate your local committees and urge them to take up the campaign which was entrusted to them primarily for their benefit; for, it was our intention to keep this immunization work in the hands of the practicing family physicians.

(8) *County Society Reports.* There are 2 other matters I wish to mention here. One concerns the work of the County Societies in relation to the Journal, and the other in relation to the editorial office. Remember, please, that reports should be sent in on or before the 20th of each month if they are to appear in the following month's Journal. You have had—and we shall send you new ones shortly—an outline of the rules regarding preparation of manuscripts. It means that they should be carefully prepared, type-written (double-spaced) reports in proper form for publication without any material amount of editing. I shall not reject a report, of course, if it is hand-written, if the reporter has not the facilities for presenting it in type-written form. I would rather have it written by hand than not at all, but I would rather have a report that is designed for appearance in the Journal rather than one that has been prepared primarily for some local news-paper; because news-paper reports are not prepared in the same form as they should be for the Journal. If they were so prepared the news-paper editor would cut out those things that are most interesting to the members of this Society. We have been lenient heretofore regarding submission of such reports, but it has been at the expense of the State Society. When a reporter has failed to send in a report of his County Society meeting by the 20th of the month we have *sent him a letter* reminding him of the fact; if, then, it is not in by the 27th, we have sent a *telegram* and, generally, that has gotten us the report. *Hereafter,* we shall not, because we cannot afford to, issue such letters or telegrams. We will be held, and quite properly, to a strict accounting in the budget. *Remember,* that each time you fail to send your report to the Editor by the 20th of the month you will deprive your County Society of its proper space in the Journal. Delayed reports cannot be published the next month—after that in which they should have appeared—because we would soon have an accumulation of old and stale reports. When it has been necessary to use letters and telegrams to secure your report, you were increasing the cost of the Journal and the State Society and, ultimately, that cost charge went back to the County Societies, including your own. In so far as that extra cost affected you, it was a just retribution; but you had no right to impose upon other members an increased expenditure to cover your negligence. We have tried this year not to nag you—as we have been conscious of doing at many times, in the past—even though we might have to sacrifice the record of having in the Journal each month a report of every meeting of every County Society that had been in session during the preceding month.

There are 2 things I want to ask you to add to your reports hereafter. I have asked many times that you give me information concerning deaths of members. It is very rare that I receive an obituary from a County Society official. Most of those published in the Journal have been picked up by our office through chance reading of newspapers. I think an obituary notice is the last tribute you can pay to a member of your Society, and you should look upon it in that light and see that the information reaches the Journal.

The second thing is—information concerning anything worthy of note that has been done by any member of the Society. Not all of the scientific papers prepared in this State are submitted to the Journal for publication, and we do not expect them, but we would like to make note of the fact that scientific work, in addition to what we have been publishing, has been produced here and published elsewhere. In the same way, if some new instrument has been devised, or anything else has been done that indicates good work on the part of the medical profession, it should find its recording in the State Journal. Submission of information of that kind will be appreciated, I assure you.

(9) *County Society Programs.* There are a number of moving picture films now available, and we shall shortly prepare for you a list of such films and of the organizations supplying them, and send to each County Society Secretary and Reporter a copy thereof so that when you want films for use at County Society meetings you will have a list of available ones from which to choose. In addition to those which deal strictly with medical affairs, may we say that the Editor of your Journal has what he thinks are some very pretty travel pictures, movies that he has, himself, made and which contain some medical features, because he has made it a practice while on vacations to visit *medical shrines.* If at any time you want diversion and entertainment of that sort at one of your County Society meetings, we will be glad to answer a call.

Now, *please remember* that hereafter your reports must come in voluntarily. The demand for *economy* makes us say that for the balance of this fiscal year, at least, we will not be able to issue extra reminders by letter or telegram. If a member observes that *his county society proceedings are not being published,* as are those of other counties, he will soon learn that *the fault is attributable to the Reporter.*

Dr. Featherston asked Dr. Scammell, in the absence of the President, Dr. Lippincott, to welcome the members of the Conference.

Dr. Scammell: Mr. President, it is always a pleasure to greet our colleagues. We who live here, in Trenton, think we have the "best city in the world". A man once said to me: "Why don't you go over to New York to practice? You have

a brother there who is very influential and who could help you, undoubtedly." I replied—"I don't want to live in New York. It takes practically a day to get anywhere to play golf." He could not understand why I wanted to live in Trenton. Well, Trenton is only a short distance from Atlantic City, from Washington, and from New York, 3 of the greatest places in the world.

In a gathering such as this we meet our fellow practitioners, commune one with another, and the man who has not the aptitude of meeting his friends and enjoying the words of praise, or of dissension, which take place, and being happy among his friends, irrespective of how much he has accumulated in this world, has not filled the niche which has been fixed for the physician.

I would like to talk of a great many things, but the program appears to be quite long and the topics interesting, so I will not take up more of your time.

Dr. Featherston: The next feature of our program concerns the control or guidance of specialism, and will be presented by Ex-President Hagerty.

The Guidance of Specialism

John F. Hagerty, M.D.,

Newark, N. J.

I am very happy to have the privilege of doing what I can toward familiarizing the profession throughout the State with the plan that was adopted at the last meeting of the State Society. It behooves us to try to make the plan work successfully. It is surprising, however, to learn how little is known about this plan, considering the fact that it was presented at the State Society's Annual Meeting in June 1931, was described to half of the County Societies we visited last year, and where I made an effort to acquaint the members with the plan and what it signified, and, further, that the original plan was published, and later, the amended plan with comments upon it, was twice published in the State in the Journal. Yet, in spite of all that, there is still much misinformation abroad regarding this plan, and many members seem never to have heard of or read about it.

Dr. Reik has already alluded to the fact that a Bill was introduced into the Legislature nearly 4 years ago having to do with this same subject, which shows first of all, that a *plan of control* or guidance *of specialism* did not originate in the State Society. We were forced to take up consideration of this matter. The Bill that was introduced in the Legislature some 4 years ago was, as those of you who are familiar with it know, a vicious affair. It would have compelled every physician in the State to take an examination before a Board composed of 15 members (homeopaths, allopaths and eclectics), and to pay a fee of $100 for the examination. No one would be permitted to take the examination unless he could show that he had spent a certain number of years in preparation, qualifying himself to practice surgery. This matter was referred by the Executive Secretary to the Welfare Committee and a Sub-Committee was set up, of which Dr. Schauffler, Dr. Coleman and myself were the members. After examining the Bill we were ready to oppose it as vigorously as we could, because we felt that it interfered with the rights of physicians for which they had paid dearly, the right to practice medicine in New Jersey.

I will try now to familiarize you with this plan, which does not interfere with the *rights* of any single practitioner of medicine. That point—I would like to emphasize. Nobody will be prevented from practicing his specialty, as would have happened with the proposed law of which I spoke. This is only a plan for the State Society to endorse those of its own members who may prove to the satisfaction of the State Society that they are qualified to hold themselves out as specialists, and who wish to have that fact approved by their colleagues. *Nobody is compelled* to apply for such endorsement, and if one does apply and fails to satisfy the Committee of the State Society, that fact will not be known outside of the Committee. No injustice; no hardship; no restriction; is placed upon any member of the profession.

I will take the time to read some of the paragraphs here and dilate upon them as I go along: "Realizing the unsatisfactory conditions growing out of 'specialism' and the abuses that have resulted from improper assumption and use of the title *Specialist,* the Medical Society of New Jersey has decided to establish a plan under which it can serve as sponsor to the public for such of its members as their colleagues recognize as being properly qualified and competent to practice as Specialists, and are deemed worthy of this Society's endorsement."

The plan requires *no new or additional legislation.* No force is asked by the State Society to compel the acceptance of this plan or to govern the action of any man throughout the state. It has no *legal* force at all. In fact, *avoidance of legal action and keeping the control of medical affairs in the hands of the organized profession* are among the merits of this proposal. This plan has been adopted by the State Society, and management of the plan is entirely within our hands.

There is nothing compulsory about it at all. "It will, however, permit those members who are, or may become, properly qualified in certain branches of medical practice to secure the endorsement of the Society, and to let the facts be made known to the public through proper medical channels." That, after all, is the crux of the thing. *It will set a premium upon meritorious work* and everything that implies—honest work—not alone skilful work.

I look upon this as a splendid opportunity to discuss this plan, because the men gathered here can explain the plan to their county societies. The plan contemplates setting up a County Society Committee and a State Society Committee. The County Committee will be composed of the President and Secretary and 3 members to be elected from and by the members of the County Society. This is a very democratic way of setting up the plan, and a very fair way; the members of the Committee are elected by and from the members of the County Society. I had the privilege of talking to the Essex County Society Councillor recently and an exception was taken to the method of selecting the county committee. Later, I will show you that the matter of deciding upon the county committee is left to the county society and some latitude is given in regard to the way they will make the selection. There will be 5 men on the county committee. No meeting can be held with less than 4 members present, in order to make this an honest determination of the fitness of a man to practice his specialty. Anybody who wants the endorsement of the Medical Society of New Jersey may make application to his county society, on blanks to be provided by the State So-

ciety, and present therewith such documents and evidence of whatever sort he may think entitles him to listing as a *specialist* in his chosen line of medical practice. I will pass this paper around, showing the effort to get the plan started on the part of Dr. Waters and myself. Some revision may have to be made later, of course; it may not yet be perfect.

The County Society will consider the applications for endorsement. This, I would like to impress upon you as showing the fairness of the whole plan: that those who apply are to be judged by their own colleagues, in their own counties, men who are in a position to know them. This is not based upon any cultural attainments or any technical skill. These will enter, of course, into the qualifications, but they are *not the only points upon which* the determination of the *qualifications will be made.* I think it is worth while *impressing that fact* upon the members of the county societies.

When the County Society has finished with its study, all of the findings are to be sent to the State Society Committee, which will be made up of the President and Secretary of the State Society, the Chairmen of the Welfare Committee and of the Board of Trustees, and the First Vice-President. It is a representative committee made up of men who have been elected by their associates to positions of trust, and I think the committee form is a splendid one. I may say, too, that *all of the findings* of the County Society Committees and of the State Society Committee, *are to be confidential.* No one else will know what has transpired in the meetings of the County or State committees.

The State Society Committee will then pass upon the findings of the County Society Committee, and determine whether to approve their findings. If they do approve, the candidate will be endorsed by the State Society at its Annual Meeting, and he will be announced as *having qualified*, and having *been recognized* as a *specialist.*

It may well be imagined that some little personal matter might interfere with the success of an applicant for qualification. Therefore, the State Society may *review the work of the County Society Committee* and may ignore the findings of that committee if it can be shown that any interference or prejudice was held in arriving at conclusions. The action of the State Society Committee is final. Much thought has been given to the plan, in an effort to make it absolutely fair.

As to the qualifications, a candidate must be known to and recognized by his professional associates as an honest, conscientious and ethical physician. Fellowship in the American College of Surgeons, or in the American College of Physicians, or a *Diploma* from one of the National Examining Boards, will be considered as *a favorable recommendation.* I want to tell you something complimentary to our State Society, which shows that our Journal is read. Dr. Reik, Dr. Waters and I have received many letters from societies in different parts of the country inquiring about this plan. Some organizations have felt quite hurt that they were not included in the list of those whose fellowship or diploma was named as of value. A certain number of organizations were mentioned to show only that we had this point in mind, and was not meant to be considered as complete and closed.

(Reading.) "Members of the Medical Society of New Jersey holding appointments on a hospital service, in a special branch of medicine or surgery, or any of the recognized specialties, whose service is sufficiently active to afford attainment of a high degree of proficiency, and the duration of whose appointment has been at least 5 years, will be deemed worthy of consideration." That is an effort to make this plan democratic and not to be unfair.

(Reading.) "Those who may later receive, from recognized colleges or other teaching institutions, certificates showing completion of post-graduate course of instruction leading to the degree of 'Master' in any branch of medicine or surgery." That, too, will influence the committees in their determination.

(Reading.) "Evidence of continuous, active, successive practice during at least 10 years, marked by study, travel, active membership in medical societies, and proof of special ability in their chosen fields of practice." In other words, one may never have been known as a specialist but if it becomes known that a man in a certain district has had the opportunity of seeing more of a certain type of disease than other men in his neighborhood, and is known to have a greater knowledge of that particular disease, he could be certified by the State Society as a specialist. That is just another effort to make the plan a fair and democratic one.

(Reading.) "The State Society, upon the advice and request of the State Society Committee on Credentials, may distribute its lists of certified specialists in such places and manner as may seem desirable for the effectiveness of this plan." That will be determined by subsequent study of plans to carry out an obligation of the State Society, which was formed to raise the standards of medical practice in New Jersey and to acquaint the public with progress in scientific medicine. We are, therefore, fulfilling an obligation of the Society in setting up this plan.

(Reading.) "The State Society Committee reserves the right to revoke any certificate issued, upon proof being shown that fraud or misrepresentation was used in obtaining certification." No fault can be found with that paragraph, it seems to me.

There is one other feature which has aroused some little dissatisfaction: (Reading.) "To defray the cost of certification and certificate, a charge of $25 shall be made, payable before the certificate is issued." That is not a permanently fixed amount and may be changed subsequently, though this much can be said for it—anything that is worth having is worth striving for and is often not appreciated if it does not cost something. The State Society will be put to considerable expense in the preparation of these forms, and we have in mind giving a worth-while certificate—in the nature of a diploma—and such things are expensive. I am informed by an engraver that the initial plate of the American College of Surgeons cost ———. The fee is not exacted upon application, and if any one fails to qualify he does not have to pay anything at all. After all, I think no great objection can be made to this.

Dr. Lippincott: I have had several inquiries regarding the phrase "3 to 5 years" relating to the term of office for the Committee on Credentials. Will Dr. Hagerty speak about that?

Dr. Hagerty: I am very glad that Dr. Lippincott interrupted me for I want to give credit, first, to Dr. Waters for the conception of this plan. The Welfare Committee of the State Society was opposed, at first, to any plan because we felt that anything of this kind might interfere with the rights of the legally qualified practitioner. Later,

through the influence of Dr. Morrison and Dr. Reik who drummed the legislative status of specialism into us, the Committee felt that it might be well to study the subject. Dr. Waters presented a plan almost 2 years ago, which has evolved into the plan presented to you now, and Dr. Waters is entitled to the credit for having first evolved a plan which, I think, will redound to the credit of the State Society. The 3-5 year period was just a tentative working time of trial which might be changed after such experience. There was no great necessity for putting in any specific time, because the plan can be altered, of course, at any time by the State Society.

It is interesting to learn that the American Medical Association, through its Council on Medical Education, has just recently gone into the work of registering specialists throughout the country. In last week's A. M. A. Journal there is an article on Physicians Specializing in Pathology, and, apparently, the A. M. A. is making a Register of Pathologists throughout the country. It is not unlikely that the Council will extend that work to registering specialists in other lines of work. We have, therefore, anticipated the A. M. A., and, in consequence, ours is the first Society to have embarked upon this work; so, I think we should take advantage of the situation, and appeal to the membership throughout the state to help us make this plan a success.

Dr. Irvin (Atlantic): Have the various specialties been classified for this plan?

Dr. Hagerty: Not yet, but that may have to be done later.

Dr. Scammell (Mercer): In our Society, some of the younger men have taken objection to the classification of *obstetricians*, thinking that might result in their losing patronage.

Dr. Hagerty: If one does exceptionally good obstetric work and becomes a specialist, it is right after all that he should profit by his experience and knowledge.

Dr. Morrison: If we classify certain men as *specialists*, people engaging their services will expect to pay a specialist's fee, and only the class of people who can pay those fees will go to specialists for such obstetric work as is done by the family physician.

Dr. Vincent Del Duca: Do you not think it is rather important to have a classification of specialists? It seems to me that now-a-days there is a little feeling against making more specialties. It might not be a bad plan to limit the number in the beginning and then enlarge upon them.

Dr. Hagerty: There has been the objection raised in Essex County that we are really putting a premium upon specialism, and will in the end increase the number of specialists. I do not think that is a very valid objection.

Dr. Reik: There are already in existence 3 classifications, any 1 of which could be used with satisfaction, I think: (1) that used by the A. M. A., in its provision for Section meetings; (2) that by the Congress of American Physicians and Surgeons, for a similar reason; and (3), that used by the American College of Surgeons. I think that in each instance the list includes 14 kinds of specialists.

Dr. Wood (Essex): Is there an intention to recognize men who are established as specialists today? Of course, this plan is mainly to control specialism in the future, but in every community there are men today who are recognized as specialists though they may not have taken an examination or received any certificate.

Dr. Hagerty: That is the purpose of parts I read in reference to periods of service in hospitals, etc.

Dr. Berkow (Middlesex): As to the County Committee, 3 members are elected for 3 years, the President and Secretary becoming members ex-officio. The question has been raised whether the President and Secretary are to remain members of that committee for 3 years?

Dr. Hagerty: No. The President and the Secretary of the County Society elected each year will be members of the committee, and 3 members additional are to be elected each year. The real intention is to select the committees from year to year.

Question: May I suggest this: Usually, when a man is elected *secretary* of a society he is elected for life. The president changes every year. It could happen that a man got his application in a month or so before the annual election. Immediately after election those matters would have to be put before another committee. If the committee members could be elected, say, 1 for 2 years, another for 4 years, and another for 6 years, so that there would be 2 who would carry over each year, the application would not face an entirely new committee.

Dr. Hagerty: Of course, everything could not be thought of beforehand. I would like to call your attention to this paragraph: "Each component County Medical Society shall set up a Committee on Credentials for a period of 3 to 5 years, composed of its President and Secretary and 3 other members to be elected by the County Society." It is optional with the County Society to carry out that portion of the plan as it sees fit.

Dr. Schwarz (Hudson): We have discussed this matter and feel that the members at large do not know what this particular recommendation regarding specialism means, and we would like to have about 450 reprints so that we could send one to each member and fully discuss it at the next meeting. Most of us understand it, but the rank and file does not, even though it was published in the Journal.

Dr. Hagerty: Reprints of this plan are being made now.

Dr. Featherston: In Monmouth County the specialists are already designated and our idea of this proposition was that the rest of the component societies might keep their standards up as high as they could so that within the first few years of this plan we would not have half of the State Society members applying for certification as specialists. The success of the plan, from my point of view, will depend upon the height of the standards that each County Society Committee holds its members to before sending them to the State Society for certification as specialists. In the smaller communities we know our specialists, and the Monmouth County Committee expects to hold

its members to a very high standard of qualification, and we do not expect to certify to the State Committee anybody who is a *casual specialist.* Our standards will include the amount of an applicant's time given to practice of the specialty for which he is asking recognition. I might say that question will probably limit us to our nose and throat men, pathologists, pediatricians, and a few general surgeons. I think it should be within the province of the State Society to designate the acceptable specialties, not so much for the surgical specialties, but certainly for internal medicine. One man will want to be known as a *cardiologist;* another, as an *internal medicine* specialist, in diseases of the chest; another, as a *medical neurologist* who is also practicing internal medicine.

Dr. Reik: No one else knows, perhaps, so well as I, how much time and labor President Hagerty has put into this matter during the past year. Even so, there will be some points suggested that were not thought of before and a few of them have been named today. In regard to the matter just mentioned by Dr. Featherston—practice considered by some physicians as making them specialists—in a paper read at the recent Annual Meeting, its author said that she practiced as a specialist, i. e., as a gynecologist and a remover of tonsils; general medicine and politics filling up the balance of her time. It was intended that the County Societies should have some latitude and that applies to some of the questions asked today. It is hoped that the standards will be set high by each County Society, but the State Society Committee will have to hold the County Society Committees up to that point; which is one of the reasons why the State Society Committee was given the right to accept or reject the matter passed up to them. Along with a recommendation by the County Society should go the records, testimony, certificates of membership in other organizations, etc., that have formed the basis of the County Society Committee's decision. The procedure of application to the County Society, and having that body pass upon it was for a specific reason. I well remember a question having come up as to how we should start, whether by simply listing that group of our members who are at present Fellows in the American College of Surgeons or the American College of Physicians, or who are Diplomates from certain National Examining Boards, and Dr. Hagerty objected—saying that he would not be willing to subscribe to such a rule, because a man might be a member of the College of Surgeons, for instance, and yet not be acceptable to the State or County Committee.

I would emphasize Dr. Hagerty's remarks about the *legal rights.* This plan does not interfere with a man's *legal right to call himself a specialist* the day after or even the day of receipt of his license to practice in the State, but it may interfere with his *moral right* to do so. This is not to be forced upon him, nor is his rejection to be considered as a punishment. It is a reward offered for doing good work—rather than a punishment for doing bad work.

Dr. Morrison: Dr. Hagerty referred to the fact that the chief object in this plan is protection of the public. Those of you who live in small towns know that fly-by-night specialists come in, clean up $300 or $400, and depart. Some young men come out of college, secure a license to practice, and after 2 or 3 years in general practice, announce themselves as specialists. It is to protect the public against such specialists, that this plan has been instituted. In this way, specialists may be given the endorsement of the County and State Societies, and their names will be published so that other physicians and the people may be informed. We hope that the County Society will see that the list comes to public attention. Atlantic County publishes its entire membership so that any one coming into Atlantic City may know who the reputable doctors are.

Dr. Featherston: Dr. Reik informs me that there is a very complete discussion of this entire subject of specialism in the Journal of March 1932. There will be technical details which will arise and I am sure that every one here is convinced of the importance of the plan and of the effort that will have to be made for its success. If the county societies begin splitting hairs it will be too bad, but if the proper attitude is taken I think the State can well be proud of establishing this plan.

Dr. Featherston appointed as a Nominating Committee, to consider the election of officers for next year, Drs. Diverty and Horre.

Luncheon was served at 1.30 p. m., at the conclusion of which the program was continued.

Afternoon Session

The Chairman presented the President of the State Society, *Dr. A. Haines Lippincott,* who said: I want to thank you for the invitation to join with you in this Conference today. I consider it a great privilege and pleasure to be here. Judging from your program, I believe it will result in profit to the State Society and its component county branches. I have always felt that the Secretary of any organization is really the making of that organization. Upon his knowledge and capabilities depends the activity of the organization with which he is connected.

I am very much interested in this plan of Dr. Waters' and I hope to do all I can this year to get it into operation. I feel that it is one of the few times that the medical profession has taken an advanced stand and offered something toward the solution of problems that confront the organization, rather than have these things in the hands of laymen, lawyers, legislators, etc., I feel that the medical profession should insist upon being considered in matters of this kind. I believe that if we stand "shoulder to shoulder" and act unitedly, there will be no trouble at all. I believe that, at this table, the first application for recognition under this plan, has just been filled out. (His own application.) I agree with Dr. Hagerty that if those who are now practicing a specialty will make the start by enlisting at once, they will contribute materially to success of the movement.

The Chairman presented Dr. J. Bennett Morrison, Secretary of the State Medical Society, who delivered the following address:

Vital Points in Recent State Society Transactions

Dr. Morrison: At the last meeting of the State Society, at the request of Essex County Society, the following resolutions were adopted. (Reading.)

> *Resolved,* (1) That inasmuch as the business management of hospitals is intimately associated with the medical and surgical care of the patients (for which hospitals exist), the Medical Staff of a hospital has a right to share

with the Board of Trustees the management of all matters distinctly medical and, to this end, should be represented on boards or committees or by effective mutual conferences; and

Resolved, (2) That approval is hereby given to the stand taken by the Essex County Medical Society and its resolutions in support of the action of the Medical Staff of the Hospital and Home for Crippled Children; and we furthermore feel that all members of this State Society should support these principles in their personal associations with hospitals.

The resolutions adopted by the Essex County Medical Society, and the principles embodied therein, were as follows:

Hospitals exist principally for the medical and surgical care of the sick, which care must be in charge of competent physicians.

Boards of Trustees of hospitals are made up of public spirited men and women who have a sincere desire to serve the community, and are banded together in order that they may make possible the service that physicians give to patients.

Medical Staffs are made up of physicians whose relative positions on the Staffs vary according as years of experience and service, and their ability, may have qualified them.

Physicians, by reason of their trained and experienced knowledge of disease and its treatment, and because of their daily contact with hospitals and patients, are better qualified to understand and to solve the professional problems of hospitals; and because of their intimate knowledge of each other and of each other's work, are the only ones able to correctly judge the relative abilities of physicians.

Boards of Trustees and Medical Staffs each have special functions, some of which are distinct. There are, however, certain functions that should be performed jointly by Trustees, who have the executive authority, and by the Staff, who have the expert knowledge. All problems connected with the essential purpose of a hospital, that is with the service which physicians give to patients, are better understood by the physician and should be solved jointly by Trustees and Staff; also problems connected with changes in the Medical Staff of a hospital are better understood by the physicians and should be solved by coöperation of Trustees and Staff.

We believe, moreover, that the Senior Staff of every hospital, because of the many years of daily contact with the hospital and because of the vast amount of service that they have given to patients of the hospital, have a heartfelt interest in the welfare of that hospital. The hospital becomes an integral part of the spiritual life of each. We believe that in shaping the administration of hospitals, physicians should have a large share, not because the physicians wish it but because hospitals need their advice.

We, therefore, believe that:

(1) Medical Staffs should have adequate representation on Boards of Trustees.

(2) We believe that there should be no change in the medical policy of a hospital without proper consultation with the Staff.

(3) We believe that no physician who has efficiently and faithfully and loyally served on a hospital staff should be removed or demoted without proper consultation with representative members of the Staff.

(4) We believe that the Medical Profession should present a united front in support of the foregoing general principles, which are in the interest of the hospitals which the profession dearly loves and of the patients whom they serve.

The adoption of these resolutions arose from a condition which confronted us in Essex County. The Hospital Board, without any consultation, removed the Medical Director who had been in service nearly 30 years, who had built up the hospital, and who was loved by many members of the profession. Of his ability there was no question. The move came as a surprise and the reaction was the resignation of 40 members of the Medical Staff. Things remained unpleasant for 11 months, but finally, partly as a result of these resolutions, the Board has rescinded its action.

I have been asked by the A. M. A. to invite Dr. Waters to Chicago, to discuss this question of specialism at the Annual Conference of the State Society Secretaries and Editors, and this will be an opportunity to place before the American medical profession something we have accomplished in New Jersey.

With regard to the transfer of a member from one component society to another: if a man is desirous of being transferred from one county to another, and we hold him up for a year of observation by the receiving society, we deprive him of rights he would have in the society for that length of time. He may be in good standing and yet we deprive him of the benefits of membership in the State Society for a year, and also of membership in the A. M. A. If he should rebel, the A. M. A. would probably sustain his appeal.

Dr. E. S. Corson (Bridgeton): Referring to the resolutions reported by Dr. Morrison, with regard to representation on Hospital Boards we have a plan whereby we have a liaison officer acting not only for the Medical Staff but also for the Board of Directors, but the Board of Directors has meetings with the Staff present, and the Staff meets with the Board at its meetings. This plan has worked out wonderfully well.

Dr. Schwarz (Hudson): Regarding the hospital proposition, in Hudson County we had 36 members thrown out of one institution because they refused to accept a new set of By-Laws. Your support is earnestly solicited in this matter of the medical men standing up for their rights.

Concerning associate membership, or the matter of accepting transfers, in Hudson County we firmly believe that it is the privilege of each constituent county society to decide in what way it wants to take in members.

Dr. Pinneo (Essex): Our By-Law is only for licentiates who have received their licenses within 2 years. We feel that we have the ideal By-Law covering this. It does not involve members coming from outside the state or from other counties. The Essex County Society at its annual meeting last month adopted an amendment to the By-Laws, whereby no member of the County Society should accept appointment on staffs of hospitals which refuse to recognize the requirement of county society memberships. This is in view of the principles that had been adopted previously. In our forthcoming bulletin, in November, we recommend drawing the attention of members to this definition of principles.

The Chairman presented Dr. J. Lynn Mahaffey, Commissioner of Health, who spoke on "Proposed Legislation Affecting the State Department of Health".

Dr. Mahaffey: I wish to say that I am very happy to be here. I have always felt that physicians throughout the State do not know much about the matters which concern public health, and I welcome the opportunity to tell you something about our work. I want also to ask you to criticize our work, ask questions, or make suggestions. We will carry them out if possible if they are good suggestions. I want to say that we have had some difficulty in keeping 135 nurses throughout the State in the Baby-Keep-Well Clinics doing their proper work, and they do get across the line some times. If that is brought to our attention in the State House, we will make every attempt to correct it.

Our State Department of Health

J. Lynn Mahaffey, M.D., Director,

Trenton, N. J.

As Director of the State Department of Health of New Jersey, I want to thank the Medical Socicty of New Jersey for the splendid support which you accredited us at the legislative hearing in March, 1932, when there was a proposal before the Legislature to change the set-up of health work in New Jersey. At a "public hearing" on that Bill, your organization was represented by Dr. J. B. Morrison, Secretary, and Dr. Henry O. Reik. Executive Secretary, and they approved the work of the Board and urged continuance of the splendid health program which was being conducted by the State Health Department.

There are 11 members on our Board, 3 of whom must be physicians, 1 dentist, 1 veterinarian, 2 sanitary engineers and 2 women members, and there must be not more than 6 members from any one political party. You see, a Board so composed should act intelligently on any health matter. The members come from all parts of the State and are conversant with health matters of their home sections. They are appointed by the Governor, and they receive no compensation for their services. The women members are selected, preferably, from among women who have had some experience in health work. Both women members at this time are much interested in child hygiene. The Board elects its Secretary and Director, and has a total of 175 employees.

I can say, without fear of successful contradiction, that health work in New Jersey is administered without the slightest semblance of political control or interference.

It was a great satisfaction to have the medical profession endorse the set-up of our Department. One of the reasons for our "pardonable" pride in the administration of health work in New Jersey is that the per capita for health work in the fiscal year just past was 13.3 cents; while, in New York State, it was almost 5 times as much, or 62.4 cents; and in Pennsylvania, 32.3 cents, or about 2½ times ours.

We talk much about economy these days, and it may interest you to know that the State Department of Health budget for the fiscal year ending June 30, 1931, was $429,000. For 1921, 10 years previously, the budget was $359,000; so we show less than a 50% increase. In a number of the other State Departments, it was far more; 510% increase for Banking & Insurance; 412% increase for Conservation & Development; 481% for Agriculture; 115% for Civil Service; and 410% for Institutions & Agencies.

Permit me to extend, through your organization, our heartfelt thanks for the splendid support and coöperation extended by the medical profession in the poliomyelitis epidemic of 1931-32. In 1916, we had reported in New Jersey 4000 cases of anterior poliomyelitis; and a mortality rate of 28%. In 1931, there were about 1150 cases reported, with a death rate of 14%, which is only half that of 1916.

Profiting by experience, the Department was able during the past summer to utilize quickly the machinery set up for the collecting of blood from former infantile paralysis sufferers. This was a concrete example of the splendid coöperation between the medical profession and our Department. It indicates clearly the facilities available for the quick checking of infectious communicable disease out-breaks.

At the present time, the State Department of Health is opening its entire record to Governor Moore's investigators from the School of Economy at Princeton University. The various lines of work in laboratory, field, district health offices, engineering problems and other phases of our work are being subjected to close scrutiny.

I am convinced that the present is a very poor time to make any material change in the set-up of our Department, which is accomplishing such remarkable results with the facilities made available by the Legislature.

After many years, our laboratories—bacteriologic and chemical—are about to be assigned additional working quarters so long needed.

The public press has recently commented favorably on the work of our Department, calling attention to the low general death rate, and low infant mortality rate attained in New Jersey in 1931. The rate last year was the same as that for 1930, which was the lowest since the State Department of Health was established 54 years ago. Death rates for tuberculosis, typhoid fever and diphtheria were the lowest rates for those diseases ever reached in this State. The editorial comment is that these facts comprise a gratifying commentary upon public health administration throughout the State, and that it is decidedly to the credit of municipal and state health agencies that the fine record of the past several years is being maintained despite the period of economic decline which it was believed would bring a marked increase in illness and a steady rise in the number of disease fatalities. Notwithstanding the favorable statistics as to the general health of our residents, I want to emphasize the statement that New Jersey should not be too optimistic over the encouraging health records which have been maintained despite economic conditions. During the past week, my office released to the general public a statement which summarizes the situation as to future effects of the economic depression. In that statement it was said that in the trail of the depression we must anticipate the after-effects on public health. We cannot but realize that a period of economic stringency, curtailed employment and enforced economy will reap its toll on our people. Encouraging as our health record has been, we should not be deceived about eventualities. Unfortunately, but certainly, malnutrition will exact its toll in a later period.

Greatly reduced consumption of milk products has challenged the service of the New Jersey Milk Conference Board. Composed of health, agricul-

ture, distributor and breeder representatives, this body is disposing of surpluses through relief channels, without demoralizing markets.

Just as the war food blockade of Central Europe exacted its penalty among children of that period, so our own must bear the ultimate effects traceable to malnutrition. Enforced idleness industrially may result in prolonging life for a time among adults afflicted with organic maladies. Traffic fatalities may be fewer, due to curtailment of car operation, and tendencies to over-eating of rich foods may be restricted. In adult life, deferring of dental and surgical demands will protrude themselves to the risks of eleventh-hour remedies. These minor gains are outweighed by the spectre of malnutrition. Unemployment and loss of economic security have made inroads on mental hygiene. One of the benefits of recovery may be that we will find people thinking more understandingly about human relationships.

On the question of proposed legislation affecting the State Department of Health it is my judgment that the Legislature should retain the milk law for supervision of State and out-of-State supplies. This legislation was enacted as a compromise among producers, distributors and health officials. It involves a tremendous amount of work and the inspection of sources of supply in more than a dozen states. Unfortunately, the necessary funds were not provided by the last Legislature for this work. We are now appealing to the Governor for $16,000 to continue this work.

Under the guidance of Dr. Samuel A. Cosgrove, of Jersey City, Dr. James E. Russell, of Lawrenceville, and John V. Bishop, of Columbus,—the Board's milk committee—supplies deemed unsatisfactory, because they failed to meet New Jersey standards, have been excluded. The milk committee promised that the product furnished to the New Jersey consumer shall be improved sanitarily. Out-of-State inspection is an extraordinary burden, and actual inspection of premises beyond the borders of this State can only be accomplished when adequate funds are provided.

The Department will again sponsor the 1932 Legislature's Bill to reduce from 72 to 48 hours the time limit in which a marriage ceremony may be performed after applying for a marriage license.

The Department is vitally interested in continuance of the District Health Officer plan. We feel that almost enough money is saved in traveling expenses from Trenton to different parts of the State to equal the salaries of these men. Furthermore, it places in 6 different points in the State, a Health Officer who has special training. The Health Officer provides a connecting link between local boards of health and the State Department.

During the past Summer, our Bureau of Venereal Disease Control performed excellent work in the center of the great oyster industry, at Bivalve, Cumberland County. The Department had a complaint from a Catholic Uplift Society for the Colored Races, at Baltimore, that many of the oyster shuckers from that city were becoming infected with syphilis at Bivalve. An investigator was sent from the Department to check up on the condition, and it was found that many of the workers had symptoms of syphilis, but that probably as many were infected in Baltimore as Bivalve. We sent a lecturer there, who interested the colored people in the program. Lectures about the horrors of syphilis were given. Moving pictures and slides were used and from the fact that they were food-handlers, we insisted that the entire group be Wassermann tested. Our Department did 508 Wassermann tests with 106 2-3-4+ reaction. We met with the Oyster Growers' Association and the local physician, and it was decided that the physician would give the positive Wassermann workers treatment at $15 per head. Payment of the bill was guaranteed by the Oyster Growers' Association, and these treatments are now being given. Another example of coöperation in health work.

Our Department did 13,000 Wassermann blood tests in 1922; and 70,000, with the same help, in 1932.

Visits made by our nurses, in 1931, numbered 288,000. Visits to Baby-Keep-Well Stations during 1931, 96,000. Our nurses made 6276 calls to expectant mothers during 1931. Defects detected in school children, in 1931, 110,432; and defects corrected, 37,094. Toxin-antitoxin given in 1931, 17,000. We keep in constant touch with 563 local boards of health throughout the State and aid and assist them in every possible manner.

The drinking water of every rural school is examined, at least once a year, by the Department. Our Department is charged with the important duty of looking after the State's sewage and its water supplies; supervision of milk and foods; child hygiene; and the public health generally.

The national death rate from tuberculosis is 71 per 100,000 population. New Jersey death rate was 65 per 100,000 population during 1931. Trenton, Atlantic City and Newark have extremely high death rates from tuberculosis in the colored race. Newark has a death rate of 308 per 100,000 population among colored people. The 12th Ward returns a death rate of 549 per 100,000 colored population. This is one of the highest death rates from tuberculosis in this country.

The Institutions and Agencies report shows clearly that almost all colored patients are being admitted in the moderately advanced stages. They also show 126 colored patient-days per case admitted; as contrasted with 207 white patient-days per case admitted. This is not a State Department of Health project but a social and economic one. The Department feels there should be some concerted effort of all branches of health work to correct the New Jersey negro tuberculosis situation.

The State Department of Health craves a closer relationship with the State Medical Society. We *believe* we could be of help to you, and *we know* you can be of help to us. The State Department of Health is practicing every economy. Encourage us.

Dr. Featherston: I am sure that we have all been interested in hearing from the Department of Health.

At this time I want to introduce to you Dr. Allen G. Ireland, Medical Director of the State Department of Public Instruction, who will speak on "The School Physician's Program".

(Dr. Ireland's School Physician Program having been published in full, and separately, in the Journal of November, pages 811-822, it is not necessary to repeat it here.—Ed.)

Dr. Featherston: We are very much indebted to Dr. Ireland. I will now call for the report of the Nominating Committee.

The Nominating Committee proposed the following officers for the ensuing year:

President, E. S. Corson, Bridgeton; Vice-President, R. I. Downs, Riverside; Secretary, A. D. Hutchinson, Trenton.

Motion was made that the report of the Nom-

inating Committee be adopted and that the President cast a ballot for the officers named; which was done, and they were declared duly elected.

Dr. Tracy called the attention of the new Secretaries to a resolution that was passed a couple of years ago—that they retain on their mailing list the names of the Secretaries, and continue to send them notices, of County Society Meetings, so that there will be an interchange of notices between the various societies.

Dr. Featherston: I want to thank every one for the time and attention given to this conference today. I am sure it has been profitable as well as a pleasure for us all.

Dr. Reik: I believe it is understood that we should meet again next year on the first Wednesday in November?

Motion was made by Dr. Tracy that the meeting be held next year, on the first Wednesday in November; which was seconded and carried.

Dr. Hutchinson said that there had been some objection made to the hour of meeting and some men had suggested that later in the afternoon would be a better time for meeting, having a dinner and then continuing the meeting after dinner, adjourning in the early evening. They objected to breaking up the entire day, particularly for those who lived at a distance.

Dr. Morrison (Sussex) suggested that if the meeting were held at 11 a. m. and work begun at that time it might be preferable.

Dr. Pinneo suggested the same hour, 11 a. m., or perhaps 12 o'clock, permitting the men to keep morning office hours.

Dr. Featherston thought the hour of meeting might be left to the Secretary.

Dr. Tracy did not think that placing the hour at 11 or 12 would make much difference. He thought Dr. Hutchinson's suggestion to meet at 3 p. m., have dinner, and follow it with an evening meeting, might be well to adopt. He suggested that a poll be taken on the first of October next, and find what hour suited the majority of the component societies.

Dr. Pinneo made a motion that this matter be referred to the Secretary in the light of remarks made. This was objected to on the ground that the program had to be arranged before the first of October. Dr. Pinneo said his suggestion was to send out a questionnaire now, or even put it to a vote among those present today. Finally, Dr. Pinneo withdrew his motion.

Dr. Morrison thought this as representative a gathering as the Conference has ever had, and he made a motion that the hour of meeting be the same as this year; which motion was seconded.

The Secretary thought all of the counties should be considered and said he would be glad to send out a questionnaire immediately and ask for immediate replies, and would then communicate the poll to the President and, if agreeable, the majority vote would be obeyed.

Suggestion was made that the Secretary call the roll and check the vote of those present.

Dr. Wood thought it difficult for those men who come from a distance to return at night if the hour is late. Said he was impressed by the fact that in meetings of hospital staffs if there is a fixed hour for closing the men are more willing to attend.

Upon roll call there were 11 votes to hold the meeting at 11 a. m.; 13 that it be held at 12; and 1 at 3 p. m.

The Secretary was instructed to get the opinions of the members who were absent and determine at a later date the hour of meeting.

Adjournment at 4 p. m.

School Health Department

SPECIAL SCHOOL PROVISION FOR THE LAME, HALT AND BLIND

Allen G. Ireland, M.D.,
Director of Physical and Health Education,
State Department of Education,
Trenton, N. J.

The writer is desirous of having your suggestions for the program of the School Physicians' Section at the next Annual Meeting of the State Medical Society to be held in June at Atlantic City.

At the last convention the suggestion of having a School Physicians' Committee in each County Medical Society was favorably discussed. It seems to have merit. The State Department of Education would then have, under this plan, a small committee of physicians familiar with local conditions to which it could present new projects, current problems, and administrative affairs. Cooperation is essential but we need a ready and efficient means of bringing it about, and it is felt that the committee plan would do that.

This department would welcome any contribution you can make relative to "trench mouth". This disease is apparently on the increase, at least it is being brought to our attention more frequently. Requests for methods of attack and prevention are being received.

State Agencies for Care of Handicapped Children

Children having serious impairments of hearing are privileged to attend the New Jersey School for the Deaf, which is located at Trenton. This school, under direction of the New Jersey Board of Education, provides an opportunity for the education of the deaf or deafened through approved methods of instruction. Any pupil with a hearing defect who fails to learn in the usual classroom situation is eligible for admission to the School. A Field Worker is available for the investigation of all reported deaf children of school age.

The New Jersey Commission for the Blind, at Newark, is concerned with the education of individuals who have a low degree of vision, or who are blind. When there are less than 5 blind or low-visioned children in a school district the Commission provides, at the expense of the State, for their education at a residential school for the blind, or arranges for their education by the Local Board of Education at a nearby public school class

for blind children already established in Newark, Paterson and Jersey City. When there are 5 or more of such children in a school district, the Local Board of Education may open a class for their instruction within their own school district. Where there are only 1 or 2 children in a district whose needs have been brought to the attention of the Commission, arrangements are made for special and extra assistance from the grade teacher, and the local board is asked to supply clear-type books and other special equipment necessary for a fair education of the children. For all public high school pupils with defective vision or who are blind, the Commission pays $275 per year to a properly qualified person for reading to and tutoring said student. For a student wishing to go to college the sum of $300 is allowed for reader and $200 toward board and tuition.

The New Jersey Crippled Children's Commission, State House, Trenton, aims to locate all crippled children within the state, and to see that adequate medical treatment is made available. This is followed by appropriate education; after which, an effort is made to find suitable employment for each student. An investigation of crippled children is made by a staff member of the Commission as reports are received.

State Health Department

IMPROVED WORKING CONDITIONS

J. Lynn Mahaffey, M.D.,
State Director of Public Health,
Trenton, N. J.

Physicians of New Jersey should be vitally interested in the plans of the State Department of Health to afford additional quarters to the State Laboratory on the fourth floor of the State House. For a quarter of a century the Bacteriologic Laboratory has been quartered on a portion of the fourth floor of the Capitol. Its appointments were not of the best. How it performed such efficient work is little short of miraculous, considering the handicaps of space, facilities for storage, and other essentials.

Under the Department's plan of re-assignment of office space, the laboratory will be given up-to-date quarters, with adequate room for proper technical work. Transfer of the administrative offices from the fourth to the second floor of the State House has resulted in the laboratory coming at last into its own.

When it is realized that some 72,000 specimens of communicable and suspected-communicable diseases, sent in by physicians and local boards of health, are examined annually in the laboratory, the outsider gets a mental picture of the volume of work performed by the Department.

There is a departmental yarn to the effect that the Department once seriously considered having the Trenton Board of Health institute suit against the State for alleged "indecent over-crowding".

A physician member of the Board, on one occasion, picturesquely described the meeting room at a session of the State Board of Health, deluged with many spectators, as worse than the "Black Hole of Calcutta".

Thanks to an indulgent State House Commission, the Health Department's patience has at last been rewarded. Members of the State Board of Health have a new pride in their positions, due to the assignment of inviting offices on the second floor for administrative purposes, having made possible the new laboratory rooms for the bacteriologists on the fourth floor.

The closer coöperation with the medical profession in solution of mutual problems, which I promised at the start of my incumbency as Director, may now be better cemented. John V. Mulcahy, Chief of the Bacteriologic Laboratory, is only too anxious to take up additional lines of work, which naturally had to be curtailed heretofore because of lack of facilities, space and personnel.

Support of the medical profession in our endeavors to make New Jersey a healthier and happier place in which to reside, is greatly appreciated. Mutual coöperation in attacking disease problems will redound to the benefit of our citizens.

Communications

MATERNAL WELFARE

(A letter from Dr. Carl H. Ill, Secretary of the State Society Committee on Maternal Welfare.)

The Maternal Welfare Committee of the Medical Society of New Jersey, appointed at the Annual Meeting in June 1931, aims to establish maternal Commissions in each County and to coördinate all local agencies working for the improvement of maternity care. All but 3 counties have already appointed such Commissions and they are already functioning.

The State Committee will hold 2 meetings each year with the various county commissions, for the discussion of maternal welfare problems; one meeting in June in connection with the State Society's Annual Meeting and the other in December, in Newark. This gives one meeting in the southern part of the state and one in the northern section.

The first meeting was held in Atlantic City, June 15, 1932, and, while not very largely attended, proved to be of great interest to members present. The second meeting was held in Newark, December 1, 1932, and was attended by 28 men representing 10 counties: Bergen, Burlington, Camden, Cape May, Essex, Hudson, Monmouth, Passaic, Salem and Somerset.

The following minutes may be of interest. Meeting called to order at 6 p. m., at the Elks Club by Dr. Bingham, Chairman.

Dr. Bingham opened the meeting by explaining that this was a "get together" session, to encourage maternal welfare work throughout the state. He urged all members present to study the needs in their own counties and offered full coöperation of the Essex County Commission toward helping them in organization work.

Dr. Wilson reported for Bergen County, explaining that the pre-natal work was fairly well taken care of in the different hospitals.

Dr. Davis, reporting for Camden County, gave statistics from the Camden City Hospital, and said also that they have not as yet had any organized work by their Commission.

Dr. J. B. Townsend spoke for Cape May County, where the work is very definitely individualized, but they have the services of a Special Nurse.

Dr. F. J. Quigley reported for Hudson County, that a Commission was appointed and they are now organizing the work.

Dr. R. A. MacKenzie reported for Monmouth

County, that they now have Clinics in the hospitals at Asbury Park and Long Branch, and 1 in the interior of the county.

Dr. William A. Dwyer spoke for Passaic County, where they are just beginning their work.

The following members also spoke: Drs. F. D. Fahrenbruch for Burlington County; J. B. Morrison for the State Society; W. B. Mount for Essex County; William T. Hilliard for Salem; Sterner for Somerset; and J. F. Condon and T. Teimer.

Meeting adjourned at 7.15 p. m., after which we had a very delightful dinner, as guests of the Essex County Commission, and heard a very interesting paper by Dr. H. J. Stander, of the Cornell Medical Center, on "Nephritis Complicating Pregnancy", at the Academy of Medicine of Northern New Jersey.

ENFORCEMENT OF MEDICAL PRACTICE LAW

(A letter dated Dec. 12, 1932, from the Secretary of State Board of Medical Examiners, reporting recent action against violators of the law.)

Dear Dr. Reik: The following is a report of the Board's activities in enforcing the Medical Practice Act since our last letter to you:

March 24—Solomon Aronson, a druggist of Jersey City, was found guilty of practicing medicine without a license and paid the penalty.

July 25—Frank J. Duffy, of Belmar, pleaded guilty in the Monmouth County Court of Common Pleas to a charge of practicing medicine without a license and paid the penalty.

July 26—Billy Blackhawk, a *medicine man*, was found guilty of practicing medicine without a license, by the Judge of the Camden District Court, and paid the penalty.

August 26—Carl Yaeger, who held himself out as a *priest physician*, was found guilty of practicing medicine without a license, by the Judge of the Mt. Holly District Court. He refused to pay the penalty and was committed to jail for 30 days.

September 19—Janette Deemer, a chiropractor, pleaded guilty before the Judge of the Atlantic City District Court to a charge of practicing medicine without a license and paid the penalty.

October 13—Antonio Fiory, of Garfield, who gave chiropractic treatments and prescribed drugs, pleaded guilty, before the Judge of the Englewood District Court, to the charge of practicing medicine without a license and paid the penalty.

October 25—Carl E. Getler, of Elizabeth, a licensed osteopath against whom a charge of practicing medicine without a license was pending in the Linden District Court, paid the penalty.

October 25—Randal J. Brown, a druggist of Trenton, against whom a charge of practicing medicine without a license was pending in the Trenton District Court, paid the penalty.

November 2—Abram Streitfeld, a druggist of Atlantic City, was found guilty of practicing medicine without a license, by the Judge of the Atlantic City District Court.

November—Florence Haines, of Ocean City, against whom a charge of practicing medicine without a license was pending in the Cape May Court of Common Pleas, paid the penalty.

November 17—Salvatore Samuni, who was practicing in Vineland and vicinity, was found guilty of practicing medicine without a license, by the Judge of the Cumberland Court of Common Pleas. His method of practice consisted in taking a lock of hair from the head of the patient for the purpose of studying the vibrations of the body—gazing into a crystal—and telling patients that they were surrounded by evil influences which could only be warded off by wearing a shield which he would make, and by giving them medicine made from herbs, etc. In summing up the case, the Judge told the defendant that the days of witchcraft were passed and that there was no place in Cumberland County for a person who practiced the methods of treatment followed by the defendant. As the defendant could not pay the penalty, he was committed to jail for 100 days, the maximum penalty allowed by the statute.

November 17—Eva Marchinsin was found guilty of practicing medicine without a license, by the Judge in the First District Court of Paterson. She was committed to jail for 30 days as she was unable to pay the penalty.

November 22—Herman J. Stockhoff, a druggist of Hoboken, was found guilty of practicing medicine without a license, by the Judge of the First District Court of Jersey City, and paid the penalty.

November 23—Dennis O. Von Dancz, of Manville, was found guilty of practicing medicine without a license, by the Judge of the Somerville District Court, and paid the penalty.

December 6—Noah Geiger, a registered optometrist, of Newark, against whom a complaint of practicing medicine without a license was pending in the First District Court of Newark, paid the penalty. He exceeded his license to practice optometry by giving medical treatments.

December 7—Nathan Wattenmaker, of Atlantic City, a licensed osteopath, was found guilty of practicing medicine without a license, by the Judge of the Atlantic City District Court. He exceeded his osteopathic license by giving electric treatments.

The license to practice mid-wifery, of Filomena Liska, was revoked by the State Board of Medical Examiners on July 20, 1932.

PERSONAL CHOICE OF PHYSICIAN

Dear Dr. Reik: I trust you will give the accompanying letter, which is self-explanatory, a place in the Journal. If the action I have taken could be followed by every member of the medical profession, I feel that all concerned would eventually be benefited; for even Insurance Companies do not desire ill will or adverse advertising.

Nov. 22, 1932

To Thomas Burke, Inc.
Real Estate and Insurance
Perth Amboy, N. J.

Gentlemen: I find that I have 6 policies in the Insurance Company of which I spoke this morning. As these policies expire you may re-write them if you can find a company that places no restrictions as to the employment of a doctor, or better still a company that advises its agents and those carrying its insurance to send all patients to the physician chosen by the patient, or, in cases where that cannot be done, to furnish first aid, preferably through the agency of a hospital ambulance, with the understanding that subsequent treatment shall be by a physician chosen by the patient or, perhaps, by the nearest relative at hand.

My action, in cancelling these particular policies, is because I feel no company has any more right to require a man to have some certain doctor than to have some certain religion, and I believe the practice of the company writing those policies, in

directing that all patients be sent to the Insuring Company's doctor, is unjust to the profession and more so to the patient.

My objections do not apply in like manner where in large industries men accept, or continue at, work under conditions that require the physician employed at the plant to be acceptable to them in case of need.

I recognize the right of every man to sell his birth-right for a mess of pottage, if he so desires, and I remain, gentlemen,

Very truly yours,

G. W. Tyrrell, M.D.

QUALIFYING AS SPECIALISTS IN OBSTETRICS AND GYNECOLOGY

The American Board of Obstetrics and Gynecology proposes to hold the first of a series of Annual Dinners for Diplomates of the Board and their friends, on the first day of the Scientific Session of the American Medical Association meeting in Milwaukee, at which time the successful candidates from the examination of the day before will be introduced in person; one or more addresses will be made by officers of the Board; and a Round Table Conference and general discussion of the activities of the Board will follow. Diplomates expecting to be in attendance are urged to make reservation for this subscription dinner, as early as possible, through the office of the Secretary of this Board. Further announcements will be made through the Journal of the American Medical Association and the American Journal of Obstetrics and Gynecology.

The next written examination and review of case histories will be held in cities throughout this country and Canada, where there are Diplomates who may be empowered to conduct the examination, on April 1, 1933.

The next general, clinical examination is to be held in Milwaukee on Tuesday, June 13, 1933, immediately preceding the annual session of the American Medical Association. Reduced railroad rates will apply.

For further information and application blanks, address the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pa.

ANNUAL MEETING OF STATE AND LOCAL HEALTH OFFICERS

Physicians of the state are invited to attend the Twenty-third Annual Conference of State and Local Health Officials, to be held in the Assembly Chamber, State House, Trenton, on the afternoon and evening of February 10. The afternoon session will be called to order at 2 p. m. by Dr. J. Lynn Mahaffey, Director of Health.

Proposed legislation dealing with: (1) swimming pools; and (2) the promotion of diphtheria immunization of children; will be the leading subjects discussed.

A playlet, written for the occasion, and showing some phases of public health work, will be presented at the close of the afternoon session.

Moving pictures of the work of a public health department will be shown at 7:45 in the evening, followed by a paper on "Health Publicity and the Press".

The chief paper of the evening will be presented by Dr. Haven Emerson, Professor of Public Health Practice, at Columbia University, on the Report of the Committee on the Costs of Medical Care, and Its Bearing on the Organization of Public Health Work.

SUBSEQUENT HISTORIES OF GLEN GARDNER TUBERCULOSIS PATIENTS

(This letter from Dr. English relates to his report published in the Journal of December 1932, pages 938-57, and is to be read in connection therewith.)

Dear Reik: I am sorry I have so long neglected to send you the analysis of the subsequent histories of patients discharged from this Institution.

These records show the subsequent histories of all patients who can be located from the time the Institution was opened, in October 1907, to June 30, 1932—during which time 10,263 patients had remained here for a period in excess of 30 days, and for whom it has been generally supposed that we must assume some responsibility as to their future. These patients have been continued in the various classes depending upon the character of involvement—Hilus, Minimal, Moderately Advanced and Far Advanced.

These records, if you compare present condition of the 25-year class patients with those (2162) of the 5-year class, from July 1, 1927, to June 30, 1932, stress the advantage of early care, as evidenced by the high percentage of those patients working who had but little disease at the time of admission. Then, they show again, that of all those who died during the entire 25 years, the greater portion of deaths occurred within the first 5 years. For instance, 52.6% of the Moderately Advanced died in the 25-year period, 28.8% died in the first 5 years; and, of the 86.9% of the Far Advanced patients in the 25-year period, 61.2% died in the first 5 years.

From this we generally infer that, if those patients can be gotten safely over the first 5 years, the road they have to travel in the next 20 years is less rugged and precarious.

STATUS OF FIRST ADMISSIONS DISCHARGED*

From October 1907 to June 30, 1932

TABLE 1

Condition on admission	Discharged	Number Located	Number Not Located	Percentage Located	Percentage Not Located
Total	10263	8948	1313	87.2	12.8
Hilus	872	728	144	83.5	16.5
Minimal	2920	2419	501	82.8	17.2
Mod. Advanced	5126	4527	599	88.3	11.7
Far Advanced	1345	1274	71	94.7	5.3

TABLE 2

Condition on Admission of Patients Located	Total Number				Positive Cases				Negative Cases			
	Located	Working	Unable to Work	Died	Located	Working	Unable to Work	Died	Located	Working	Unable to Work	Died
Total	8948	3585	1274	4089	4658	966	555	3137	4290	2619	719	952
Hilus	728	585	96	47	—	—	—	—	728	585	96	47
Minimal	2419	1446	418	555	486	208	100	178	1933	1238	318	377
Mod. Advanced	4527	1465	682	2380	2939	681	384	1874	1588	784	298	506
Far Advanced	1274	89	78	1107	1233	77	71	1085	41	12	7	22

TABLE 3

PERCENTAGE DISTRIBUTION OF THE PATIENTS LOCATED

Condition on Admission	All Cases			Positive Cases			Negative Cases		
	Working	Unable to Work	Died	Working	Unable to Work	Died	Working	Unable to Work	Died
Total	40.1	14.2	45.7	20.7	12.0	67.3	61.0	16.7	22.3
Hilus	80.3	13.2	6.5	—	—	—	80.3	13.2	6 5
Minimal	59.8	17.3	22.9	42.8	20.6	36.6	64.0	16.5	19.5
Mod. Advanced	32.3	15.1	52.6	23.2	13.1	63.7	49.4	18.8	31.8
Far Advanced	7.0	6.1	86.9	6.2	5.8	88.0	29.3	17.1	53.6

*Of the 12,883 patients discharged, there were 10,263 first-admissions with a residence of more than 30 days, of whom 50.05% were positive and 49.95% negative.

STATUS OF FIRST ADM'SSIONS DISCHARGED*

From July 1, 1927, to June 30, 1932

TABLE 1

Condition on admission	Discharged	Number		Percentage	
		Located	Not Located	Located	Not Located
Total	2162	2057	105	95.1	4.9
Hilus	338	323	15	95.6	4.4
Minimal	683	645	38	94.4	5.6
Mod. Advanced	1040	991	49	95.3	4.7
Far Advanced	101	98	3	97.0	3.0

TABLE 2

Condition on Admission of Patients Located	Total Number				Positive Cases				Negative Cases			
	Located	Working	Unable to Work	Died	Located	Working	Unable to Work	Died	Located	Working	Unable to Work	Died
Total	2057	1373	289	395	681	252	127	302	1376	1121	162	93
Hilus	323	317	4	2	—	—	—	—	323	317	4	2
Minimal	645	514	83	48	71	43	9	19	574	471	74	29
Mod. Advanced	991	517	189	285	532	195	109	228	459	322	80	57
Far Advanced	98	25	13	60	78	14	9	55	20	11	4	5

TABLE 3

PERCENTAGE DISTRIBUTION OF THE PATIENTS LOCATED

Condition on Admission	All Cases			Positive Cases			Negative Cases		
	Working	Unable to Work	Died	Working	Unable to Work	Died	Working	Unable to Work	Died
Total	66.7	14.1	19.2	37.0	18.7	44.3	81.5	11.8	6.7
Hilus	98.2	1.2	.6	—	—	—	98.2	1.2	.6
Minimal	79.7	12.9	7.4	60.6	12.6	26.8	82.0	12.9	5.1
Mod. Advanced	52.2	19.0	28.8	36.7	20.4	42.9	70.2	17.4	12.4
Far Advanced	25.5	13.3	61.2	18.0	11.5	70.5	55.0	20.0	25.0

*Of the 2924 patients discharged, there were 2162 first-admissions with a residence of more than 30 days, of whom 33.0% were positive and 67.0% negative.

JERSEY CITY MEDICAL CENTER

Friday Afternoon Practical Lectures

Program for February 1933

February 3—"The Practice of Traumatic Surgery." Dr. John J. Moorhead, New York, Professor of Surgery, Columbia University—New York Post-Graduate Medical School.

February 10—"How to Examine Patients with Fracture of the Skull and Their Immediate Treatment."
Dr. Wells P. Eagleton, Newark, Medical Director of the Newark Eye and Ear Infirmary; Chief of Division of Cranial Surgery, Newark City Hospital.

February 17—"Obstetrics and Gynecology—Odds and Ends."
Dr. Frederick C. Holden, New York, Professor of Obstetrics and Gynecology, New York University—Bellevue Medical School.

February 24—"Hoarseness."
Dr. Chevalier L. Jackson, Philadelphia, Professor of Clinical Bronchoscopy, Temple University Hospital.

Lectures are given in the Nurses' Auditorium and begin promptly at 4.30 p. m. Members of the profession are cordially invited.

"CANCER! THEN AND NOW"

From the "Foreword" of the book bearing the above title we have abstracted the following explanation of its having been pubilshed.

"During 1931, the New York City Cancer Committee prepared a pictorial exhibit comprising a series of charts designed to show the development, from earliest times to the present, of methods of diagnosis and treatment, particularly with reference to *cancer*. This exhibit was first shown at the Clinical Congress of the American College of Surgeons, in New York, October 1931, and later at the New York Academy of Medicine through the courtesy of its Trustees. So many and so favorable were the comments that the Committee was encouraged to arrange for publication, in book form, of the charts comprising the exhibit, with a few explanatory words by various qualified authors, on the page facing each chart.

The object of the exhibit and of the book is to arouse an intelligent public interest in the subject of cancer, its treatment and its control; and so, to further support of research, of public education, and of adequate hospital facilities, since no hospital should accept a cancer patient unless the proper means for diagnosis and treatment are available within its walls."

To the Editor, this book appears to be the most satisfactory presentation of the cancer problem he has ever seen; and that is especially true with regard to the needs of the layman, for the reason that any reasonably intelligent human being can read, visualize, and comprehend this story of cancer. There are many practicing physicians who would profit from a careful study of this 75-page book, and no physician need hesitate to put a copy of it into the hands of a "cancer patient"; for *it will explain without alarming* the patient.

Dr. E. J. Ill, 1004 Broad Street, Newark, who is Chairman of the New Jersey Section of the American Society for the Control of Cancer, and who is deeply interested in this particular feature of medical educational work, has authorized us to say that he has undertaken to supervise and encourage the sale of this informative book in New Jersey, and will be pleased to accept orders for any number of copies at the price of $1 each.

We are happy to endorse this book as the most instructive piece of cancer literature that has as yet passed under our observation.

Woman's Auxiliary

Gloucester County

Reported by Mrs. Henry B. Diverty

The Woman's Auxiliary to the Gloucester County Medical Society held a regular meeting Thursday evening, December , at the Pitman Golf Club. Mrs. Elwood Downs, President, presided. Members present were Mrs. J. Harris Underwood, Mrs. Paul Pegau, Mrs. Ralph Moore, Mrs. C. H. Bowersox, Mrs. Fuller Sherman, Mrs. H. B. Diverty, of Woodbury; Mrs. Ralph Hollinshed, of Westville; Mrs. Knight, of Pitman; Mrs. Pedrick, of Glassboro; Mrs. Crain, of Mt. Ephraim; Mrs. Livengood, of Swedesboro; Mrs. Chester I. Ulmer, of Gibbstown; Mrs. Gardiner, of Gibbstown.

The Secretary read a communication respecting flowers sent by our society for the funeral service of our beloved National Auxiliary President, Mrs. Walter Jackson Freeman, of Philadelphia.

After the business meeting a social hour followed. Later we joined our doctors in the dining room, where a fine collation was served.

Essex County

Reported by Mrs. R. M. Rogers

Preceding the regular meeting of the Auxiliary, the members of the Executive Board were guests of Mrs. Don A. Epler at luncheon in the Newark Elks' Club. The meeting was held in the Academy of Medicine, 91 Lincoln Park, at 2.30 p. m., January 23.

Dr. Walter B. Mount, Chairman of the Maternal Welfare Commission of Essex County, gave an outline of the work done by that Commission since its beginning some 10 years ago.

Mrs. Charles F. Adams, President of the State Society Auxiliary, who was scheduled to address the Auxiliary, was unable to attend, on account of illness.

There was a rather short business meeting in which the President, Mrs. Theodore Teimer, presided and called for reports from the various committee chairmen. Notable among these reports was one from the Social Committee, headed by Mrs. Earl Snaveley, which showed a gain of almost $200 from the Card Party held in November. This amount was added to our growing Scholarship Fund. Mrs. Charles Englander, as Chairman of the Committee on Clippings, read the recent editorial in the Journal of the American Medical Association, by Dr. Fishbein, on the Costs of Medical Care.

Mrs. William J. Donahue was appointed Chairman of the Nominating Committee.

It was announced that 2 dates have been secured, on station WAAM, for broadcasting by Mrs. E. C. Taneyhill, February 7 and 14, and 3.45 p. m. Her subjects for those talks are—"You Are

What You Eat" and "The Fourth 'R' in Education".

Following the meeting, tea was served in the parlors of the Academy by the Social Committee.

Union County

Reported by Mrs. H. V. Hubbard

A meeting of the Woman's Auxiliary to the Union County Medical Society was held in the home of Dr. and Mrs. P. DuBois Bunting, in Elizabeth, on the evening of January 11, under the presidency of Mrs. Harold Corbusier.

After the Secretary's and Treasurer's reports had been accepted, the Hygeia Committee Chairman reported that a card party had been held in the home of the President on November 16, and had netted the sum of $22.25, which would be used to purchase subscriptions for school libraries in the county; and 5 private subscriptions had also been sent in.

Reports from the Open Meeting of the Woman's Auxiliary to the Medical Society of New Jersey, which was held in Trenton on January 9, were given by Mrs. F. A. Kinch, Mrs. George L. Orton, and Mrs. H. V. Hubbard. "Private and School Physicians", "Untruthful Adds", "Cost of Medical Care", and the "Handbook for the Auxiliaries" published by the Auxiliary to the A. M. A., were some of the things discussed. This Auxiliary voted to purchase 2 copies of the Handbook for the use of its officers or members.

The matter of "Mosquito Extermination" was discussed and it was voted to consult with our advisory board from the Union County Medical Society before taking action.

The revised Constitution was discussed and the motion was carried to have Article 5, Section 1 read, "The regular meeting of this Auxiliary, just preceding the Annual Meeting of the Auxiliary to the Medical Society of New Jersey, shall be and shall be called the *Annual Meeting* of this Auxiliary." This change of date was made to effect uniformity throughout the state.

The Auxiliary voted to send the usual subscription to the fund for the Annual Meeting of the State Auxiliary next June.

Upon motion, the meeting closed and went into a postponed Annual Meeting from last October. After the Treasurer and Nominating Committee had reported, the meeting adjourned, upon motion, until next April when the first Annual Meeting under the revised constitution will be held.

Dainty refreshments were served by the hostess and a social hour was enjoyed.

County Society Reports

ATLANTIC COUNTY

John S. Irvin, M.D., Reporter

DECEMBER MEETING

The Annual Meeting of the Atlantic County Medical Society was held December 9, at the Chalfonte Hotel, with 47 members present.

Dr. Darnall reported progress for the Library Committee.

Dr. W. Blair Stewart, Chairman of the Public Health Committee, stated that he felt that the Society should go on record as endorsing the ordinance prohibiting the automobiles equipped with loud speakers for advertising purposes now going around the City. A motion was passed endorsing this ordinance.

Dr. Stewart also called to the attention of the members the "Final Report of the Committee on the Costs of Medical Care", and the editorial regarding it in the A. M. A. Journal of December 3. He said that every member of the medical profession should take the time to study that report carefully. (It can be purchased in book form from the University of Chicago Press, 5750 Ellis Avenue, Chicago, price $1.60.)

A letter from Dr. Joseph H. Marcus, tendering his resignation as Secretary, was read and accepted with regret. The secretary was instructed to write a letter to Dr. Marcus embodying the appreciation of the Society for his splendid services.

The following officers for 1933 were elected: President, C. H. de T. Shivers; Vice-President, D. B Allman; Secretary-Treasurer, J. S. Irvin; Reporter, L. M. Walker; Historian, H. L. Harley; Drs. W. B. Stewart, Sr., and W. E. Darnall, Delegates to the State Society, term expiring in 1936, with Drs. Samuel Stern and Samuel Gorson as Alternates.

Member of State Nominating Committee, Dr. W. E. Darnall; Board of Censors, Dr. H. S. Davidson.

Dr. Shivers then expressed his appreciation for the past year's programs and stated that he hoped he would be able to make the 1933 series as interesting. He thanked the Society for the honor bestowed upon him in making him President.

The Treasurer's report for 1932 was read and showed a balance of $420.17. The report was accepted.

Upon the suggestion of the Treasurer, a motion was passed fixing the annual dues for 1933, at $12.

Dr. Joseph Poland was appointed Auditor of the Treasurer's accounts.

Dr. Scanlan urged the matter of expressing to Dr. Marcus our appreciation for his services as Secretary, stating that he had been a most ardent and faithful worker and that he hoped Dr. Marcus would not be compelled to stay away from Atlantic City but would soon be able to return and take his place in the medical profession again.

Dr. Scanlan called to the attention of the members an editorial in the New York Herald-Tribune concerning the Report of the Committee on the Costs of Medical Care and said that every member of the Society should be acutely interested in studying these reports so that when the time comes to protest or approve their recommendations each will be fully familiar with the situation. He believed that the general medical practitioner was going to be pushed out by the big medical centers and that we were headed toward *state medicine;* and that could not be a satisfactory plan for the people at large.

Dr. J. B. Morrison, Secretary of the State Society, spoke regarding the Waters plan for endorsing specialism.

He stated that this was not a new idea, as seemed to be the impression held by a number of men, but had come up as early as 1929 and that the State Society had been forced to take some definite stand before the legislature does so. The State and County Committees are more familiar with their members' moral and ethical standing than the politicians are; so, they should now have it under the control of the medical profession instead of under state control.

The names of those men recognized as specialists in their fields will also be published so that the people will know who is competent to do the work they want done.

Dr. Morrison said we are just a step ahead of the A. M. A. but that the Association's recommenda-

tions will be based on "scientific knowledge" alone, whereas we have the advantage of having the moral and ethical standing in addition to that of their scientific ability.

Dr. Morrison also spoke regarding the Report on the Costs of Medical Care, stating that every man in the medical profession should spend the time to study thoroughly the report made by that Committee and that the Society should take some definite stand regarding this matter.

A motion was passed that a Committee, consisting of the Board of Censors, the President and the Secretary, be formed to pass upon the qualifications of members who may desire the State Society's Certificate of specialism.

Dr. Mason then told the members that Dr. Davidson had recovered from his recent accident and was back at work again. He thanked the members for their attendance and the committees for their work during the past year.

The first paper of the evening was read by Dr. Henry Dintenfass, Professor of Otology at the University of Pennsylvania, who spoke on "Mastoiditis, A Differential Diagnosis". Dr. Dintenfass' paper was illustrated with moving pictures explaining the points in diagnosis and showing operations in mastoiditis and sinus thrombosis. (It was submitted to the Journal.)

The second paper of the evening was read by Dr. Samuel B. English, Medical Director of the New Jersey Sanitarium for the Treatment of Tuberculous Diseases, Glen Gardner, on the Collapse Therapy of Pulmonary Tuberculosis.

Dr. English's paper consisted largely of a lantern slide demonstration and his remarks were in large measure the same as in his paper, in the December Journal.

January Meeting

The regular monthly meeting of the Atlantic County Medical Society was held January 13, at Chalfonte Hotel, with 55 members present.

The following Committees were appointed to serve for the coming year:

Public Health: W. Blair Stewart, Chairman; E. H. Harvey and B. G. Davis.

Library: W. E. Darnall, Chairman; H. S. Davidson and C. C. Charlton.

Post-Graduate Education: W. J. Carrington, Chairman; D. W. Scanlan and H. S. Davidson.

Broadcasting: W. P. Conaway, Chairman; A. G. Merendino and R. B. Durham.

Entertainment: D. C. Reyner, Chairman; G. A. Poland and R. E. Durham.

Delegates to Other Societies: W. P. Conaway. S. Barbash and W. Blair Stewart.

Dr. Carrington, Chairman of the Post-Graduate Education Committee, reported that Drs. Kilduffe, Scanlan and himself had met with the Cape May County Committee and decided to hold 1, 2 or 3 post-graduate courses. In 1930, the courses were taken by 30 members. in 1931, we enrolled 87. This year we will have, certainly, one course in medicine, for which a tentative program is now being arranged. The fee charged for the first course will be $15. Choice of subject for a second course is leaning toward applied neurology, as given in Essex County last year, and where it had to be conducted in 2 sections because of the large number of men attending. The price for both courses will be $25 and we must have 30 subscribers for each course.

A letter, requesting our support in maintaining the Army Medical Corps Reserves, was read by the Secretary and it was decided that the Society should go on record as in favor of retaining these reserves.

A letter from J. A. Miller, of the Associated Adjustment Bureau, regarding its plan of collecting for physicians, was tabled for future reference.

Dr. Gustave Gehring tendered his resignation, after 40 years of membership in the Society, and he was immediately and unanimously elected an Honorary Member.

Applications from Drs. George Schwarzkopf and J. W. Spear were referred to the Board of Censors.

Dr. J. J. Jacobson was elected to active membership in the Society.

The paper of the evening was presented by Dr. John A. Kolmer, Professor of Medicine, Temple University, Philadelphia, the title of which was—"The Present Status of Our Knowledge Concerning Prophylaxis and Treatment of Infantile Paralysis." (Promised for later publication in the Journal.)

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular monthly meeting, which was also the Annual Meeting, of the Bergen County Medical Society was held at the Elks Club in Hackensack, Tuesday evening, January 10.

The meeting was opened by Dr. Walter Schmidt and the report of the Executive Committee was read and accepted. New members were elected as follows: To Regular Membership: Drs. T. Bosch, Midland Park; J. A. Rube, Ridgewood; and, R. E. White, Glen Rock. To Associate Membership: Dr. C. W. Harreys, Ridgewood. To Junior Membership: Drs. Abraham Goldfarb, Rutherford; B. Arthur Smith, Ridgewood; and R. E. H. Duisberg, Teaneck.

The report of the Treasurer was then read and the question of lowering the dues was brought up, and discussed at great length. Dr. Snedecor pointed out that while $20 per year seemed very much in these hard times, the benefits derived from membership in the County Society were legion. Half of the amount goes for assessment to the State Society, for which membership entitles you to Group Insurance rates, including Automobile, Malpractice, and Health and Accident types of insurance. The saving on these items alone is more than the yearly dues. Also included in this assessment is subscription to the State Society Medical Journal. The other half of the dues goes toward defraying the expenses for collations at the regular meetings, salary of the County Society's Executive Secretary, etc. It was then decided that the dues remain as they were.

Next order of business was the election of officers. The Nominating Committee reported the slate as follows: President, Dr. Samuel Alexander; Vice-President, Dr. Arcangelo Liva; Treasurer, Dr. Michael Sarla; Reporter, Dr. Charles Littwin; Secretary, Dr. S. T. Snedecor. As there were no other nominations from the floor, the Secretary cast one ballot for the entire ticket.

Dr. Schmidt then made a very touching "Valedictory" and then asked that Dr. Alexander be escorted to the Chair; and, in very inspiring words, handed over to him the "Gavel".

Dr. Alexander, in accepting the Presidency, made a touching speech, and a plea that the Society dedicate itself for the next year to improving the Physician's economic status and giving serious thought to the reports from the National Committee on the Costs of Medical Care.

The Executive Secretary submitted his report as follows: In listing the activities of the Executive Office of the Bergen County Medical Society un-

der the new régime adopted in March 1932, it is extremely difficult to give you an exact idea of the type and amount of work that has been accomplished. Those of you on the Executive Committee realize the amount of time given to committee meetings, and you know, I think, that in every way possible this office has coöperated with the different committees so as to lighten their burdens. The most important and valuable activities to the Society can hardly be enumerated; the effects and results are such that a finger cannot be placed upon them.

An indication of the amount of work done may be seen in figures concerning the correspondence that is carried on by the Executive Office. From March 1932 to date over 200 letters, of which there are carbon copies on file at this office, were sent out in answer to letters from laymen, members, County Medical Societies, the State Society, etc. This does not include mailing of the Bulletin, nor does it include the notification cards for meetings. Of the last, there have been over 350 cards mailed. All mail and other work requiring the outlay of money have been handled and distributed in as economic a way as possible.

Your Executive Secretary has operated his car, covering about 1500 miles in the 10 months' period. He has engaged a secretary to further facilitate the efficiency of his office. About ⅔ of this secretary's time is taken up entirely with this Society's work. These services have been without expense to the Society.

A very brief summary of some of the activities follows: (1) The Bulletin has been enlarged and further development is expected. We hope to have this pamphlet on a paying basis in the very near future. (2) A close and effective liaison has been built up with the news-papers in the locality and this office has coöperated with the Public Relations Committee in supplying items for newspaper publication. (3) The Roster was corrected and edited by this office. The files have been systematized by cross-indexing. Additional addressograph plates have been made and the entire mailing list checked and corrected where needed. This brings our mailing list up to date and I am pleased to report that it is in as perfect a condition as possible. I wish to take this opportunity to thank the doctors for reporting to me changes of address, and the Society for providing this office with the addressograph, which has greatly facilitated matters, saving hours of time each month. (4) We have been coöperating with Mr. Peter Halsted, Deputy County Director of Emergency Relief, and 29 medical relief calls have been taken care of since September 1; supplying family physicians where possible. This is a step in the right direction. Vouchers were made up and ordered printed for this Relief work, and same were distributed upon request to the members; 2 "throw-outs" of interest to members in regard to relief work, were distributed for Mr. Halsted. (5) Various insurance companies were gotten in touch with in regard to using their educational pamphlets with Bergen County Medical Society's stamp upon them. Corresponded with various County Medical Societies in regard to their advertising procedures and the fundamental principles governing their acceptance of advertisements. (6) A supply of Rosters was sent upon request, to various organizations throughout the county. (7) Made up outing and inspection trip to Walker-Gordon Laboratories, at Plainsboro, and fall "golf" meeting at the Hackensack Golf Club, Oradell. Assisted in Spring Rally at Bergen Pines and Councilor Meeting with the Delegates and Alternates at the Preakness Golf Club previous to the State Convention, at Atlantic City. I also attended the State Convention, and made arrangements for Bergen County Night. (8) Established social contact with Bergen County Health and Sanitary Association, inviting them to some meetings of interest to them. The same was true of Hudson, Essex and Passaic County Medical Societies. Mailing list was increased by including officers of these organizations. (9) Attended all committee meetings, Public Health Nursing Conferences and regular meetings. (10) Notified with personal letters all Delegates to the State Convention. (11) Arranged with Studio for photo-roster.

In regard to coöperation with various committees, the following work was done by this office:

Business—Sent out a circular letter on "collections", for Dr. James, to all members.

Cancer—Personal letters sent to members of Dr. Corn's committee, to swell attendance at meetings.

Clinic—Letters to various hospitals for information on clinics.

Entertainment—One set of envelopes for all members, 2 sets of postals sent out, advertising Annual Dinner. Notified by personal letter 25 to 30 new members.

Ethics—Corresponded with doctors in regard to unethical advertisement.

Maternal Welfare—Sent to New York for material for Dr. Wilson.

Scientific—Discussed program each month with Dr. Taylor as to lay-out for Bulletin.

School Physicians—Printed letters for School Physicians' Meeting at State Street School, Hackensack, and printed programs. Same were sent out to 500 school physicians, principals, supervisors, County Health Nurses, Boards of Education, etc.

Post-Graduate—Made up and had Tuberculosis Course folder printed and sent to all members and officers of adjoining societies with personal letters inviting them to avail themselves of this free course.

Public Health Nursing—Arranged for and attended all meetings.

Public Relations—Wrote members of Dr. Farmer's committee re poor attendance. Sent copy of minutes of meeting to each member. Sent cards to all Society members re toxin-antitoxin appointments and supplied more upon request.

Membership Committee—Sent out 97 personal letters to non-members with "ethics pamphlet" and State Society pamphlet, in April. Thirty personal mimeographed letters to non-members in December. Made up and had printed new application blanks. Made up "spot map" and distributed to all members.

Membership—Kept in touch with Court House, getting names of newly registered physicians and writing them accordingly.

Treasurer—Wrote about 30 personal letters to delinquents.

Secretary—Sent out during December, 17 personal letters to new members and approximately 70 mimeographed letters to members not insured in the Group Liability Insurance.

Numerous personal conferences with committee chairmen were held planning their programs. Due to the many personal calls to the Executive Committee and Committee Chairmen, notifying them of meetings, I have changed my phone service, thus saving the Society several dollars each month.

I wish at this time to thank the officers and members for their assistance and coöperation.

The Scientific Program was then turned over to

Dr. Taylor, who introduced the following speakers: Drs. Charles Hendree Smith of New York City; L. P. Sutton, of New York City; and Katherine Dodge, of Bellevue Hospital Staff, New York City.

Their subject was "The Modern Treatment of Chorea", illustrated by motion pictures; very instructive presentations. After a general discussion, the meeting was adjourned at 11.30 p. m.

BURLINGTON COUNTY

Joseph M. Kuder, M.D., Reporter

The regular January meeting of the Burlington County Medical Society was held at the Fairview Sanatorium for Tuberculosis, at New Lisbon, January 11, at 1.30 p. m.

The President's chair was gracefully and capably occupied by the President-Elect, Dr. John S. Conroy, of Burlington, who made his official début most auspiciously on this occasion.

There were 25 members of the society present, and the meeting was enriched by the presence of the following guests: Vice-President of the State Society, Dr. Lancelot Ely and Mrs. Ely, of Somerville; Drs. Bahrenblatt, Medical Director of the Deborah Sanatorium at New Lisbon; Heinecker, of Browns Mills; and Henry B. Diverty, of Woodbury.

The Society congratulates itself upon the election to membership of Drs. Edward James Muldoon, of Florence, E. Vernon Davis, of Vincentown.

The minutes of the previous meeting being read and approved, the society, in the absence of any unfinished business, proceeded with the following deliberations.

Dr. Marcus Newcomb was delegated by the society to send a letter of condolence to Mrs. S. R. Maul, widow of Dr. S. R. Maul, of Riverside, and to Dr. Elizabeth Love, of Moorestown, relative to the death of her oldest son. The society wishes to express its deepest sympathy and participation in these bereavements.

The question—of establishing a Burlington County Birth Control Center, in conjunction with the Burlington County Hospital—was discussed, and a committee, consisting of Drs. Frederick D. Fahrenbruch, chairman; Howard C. Curtis, and Louis Viteri, was appointed to report the results of a survey on this question at the next meeting.

The question of promulgating a series of lectures on "sex hygiene", to be presented before various Parent-Teacher Associations and public school pupils, was favorably considered, and a committee, consisting of Drs. Howard C. Curtis, chairman; Parry M. Scott, and Richard D. Anderson, was delegated to formulate and define the policies and conduct of this series of talks, and to present a report at the next regular meeting.

The recent report on the Costs of Medical Care was deemed worthy of a special session for deliberation, and will be discussed thoroughly at a meeting called by the Society for this purpose on February 2, at 9 p. m., at the Burlington County Hospital, Mt. Holly.

The Post-Graduate Committee announced the subjects and speakers selected for the next course, beginning Thursday, March 6, at the Burlington County Hospital. The enthusiastic reception accorded to this series of lectures last year promises to be eclipsed this year, and all but a full quota was immediately obtained for enrollment.

The meeting was then turned over to Dr. Samuel F. Busansky, Chairman of the section on the Practice of Medicine, who announced the subject—"Cardiovascular Diseases in Every-Day Medicine"—and presented Dr. E. J. G. Beardsley, of Philadelphia, as the speaker. In his characteristically capable manner, Dr. Beardsley elucidated his subject at considerable length, and gave a very comprehensive résumé of important diagnostic factors in relation to heart disease. A spirited discussion and prolonged applause testified to the excellence of his presentation and the appreciation of his audience.

Dr. Busansky then introduced the Medical Director of the Camden County Tuberculosis Sanatorium, Dr. Martin H. Collier, who presented a valuable and illuminating thesis, on—"Important Points in the Diagnosis of Disease of the Chest". He limited his paper to a dissertation of incipient pulmonary tuberculosis, and generously imparted to his audience many important diagnostic facts gleaned from his wide experience in his chosen specialty. The society testified its gratitude to Dr. Collier for his excellent paper, and the meeting was adjourned—wthout doxology and benefit of clergy—to the dining room of the Sanatorium, where a clinic in practical gastrodynamics was indulged in by all the members and guests of the Society.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

December Meeting

The regular meeting of the Camden County Medical Society was held at the City Dispensary, December 6, at 9 p. m., with President A. B. Davis in the chair, and 72 present.

Dr. S. S. Lewandowski took the Society oath of membership.

Dr. A. B. Rogers, Chairman of the Business Committee, moved that the annual honorarium of $10 to the Assistant Secretary and Assistant Treasurer be granted as usual. This motion was approved by the Society.

Dr. B. Franklin Buzby, Chairman of the Program Committee, announced the desire to move the program for the January meeting forward to the February meeting, and it was the further desire of the committee to hold a meeting devoted to discussion of the report of the Committee on the Costs of Medical Care. This was discussed by Drs. Macalister, Lewis, Meyer, Rogers and Lippincott.

A motion was made by Dr. T. K. Lewis, seconded by Dr. Meyer, that the President, in conjunction with the Program Committee, select members of this society to study that Report of the Committee on the Costs of Medical Care and report to the Society at its regular meeting in January. This motion was duly voted upon and passed.

The Report of the Committee on Post-Graduate Education was given by Dr. D. F. Bentley, Jr. He reported that the subjects of the lectures had been selected. It was planned to start the course this year on March 1, 1933, in order that it would finish before the advent of warm weather.

Drs. Corpening, Driscoll, Wiant and Hays were duly elected to Active Membership; Drs. John Leavitt and John Marcy to Honorary Membership.

The Scientific Program consisted of a symposium on the "School-Child". Dr. Helen F. Schrack spoke on the "School Physician"; Dr. A. H. Shafer, the Otolaryngologist; Dr. A. M. K. Maldeis, the Ophthalmologist; and Dr. B. F. Buzby, the Orthopedist.

A liberal discussion followed, in which Drs. Rogers, Shipman, Kline and Pratt participated.

Dr. Shipman introduced Miss Helen Reiners, who spoke on the "Sight-Saving Class" conducted by the Board of Education. Drs. Schrack and Maldeis closed the discussion.

A communication from Mrs. Levi Hirst, thanking the Society for flowers sent to Dr. Hirst, was read.

JANUARY MEETING

The Camden County Medical Society held its regular meeting on January 3, in the Camden City Dispensary, with Dr. A. B. Davis presiding.

The Business Committee did not meet at the accustomed time, prior to the regular meeting, so there were no committee reports.

Dr. William J. Browning, of Merchantville, was elected to active membership.

The Business Committee authorized the Treasurer and Secretary to drop the following members for non-payment of dues: Drs. Lawrence H. Marshall, James M. Vaughan, Samuel Goldman, Meyer Segal and Eugene H. Stillman.

The program of the evening was opened by Dr. A. C. Morgan, of Philadelphia, a member of the National Committee on the Costs of Medical Care, who outlined the *Minority Report* and spoke with enthusiasm for retention of the family physician as the key to successful medical economics. The formal discussion was conducted by the Committee appointed by the President for this purpose: Drs. T. K. Lewis, Hyman I. Goldstein, J. S. Shipman and Alexander Macalister. Each spoke on a different phase of the Committee's Report. Following this, the discussion was open to the membership: Drs. Pratt, Hollinshed, Casselman, Reik, Goldstein, Morgan, Lippincott and Meyer participated.

Dr. William Shafer moved that a Committee be appointed by the President to study the Report of the Committee on the Costs of Medical Care, and report at each meeting hereafter the results of their findings. This motion was seconded by Dr. George Meyer and passed unanimously.

Dr. Shope moved a vote of thanks from the Society to Dr. Morgan for his Address, and the motion was enthusiastically adopted.

Dr. H. F. Palm was presented with a certificate by the Society in commemoration of his 50 years' active service in the practice of medicine in Camden County. Dr. Alexander Macalister made the formal presentation. The recipient was accorded an ovation by the Society. In his response, he cited the fact that he represented the sixth successive generation of his family in medicine and each preceding generation had contained a physician or surgeon of prominence. His great-great-grandfather was one of the physicians in attendance upon George Washington during his fatal illness.

The President read a message from the Treasurer informing members that January 25 was the final date for payment of dues in time for the Official List.

Dr. Hyman Goldstein made a motion that this Society arrange, through its Business Committee, to carry on the books those members who are unable to meet the payment of dues immediately. This motion was seconded by Dr. George Meyer and passed unanimously.

Guests at the meeting, including Dr. A. C. Morgan, were: Drs. Conroy, of Burlington; Tracy, of Beverly; Diverty and Hollinshed, of Gloucester County; and Reik, of Atlantic City. There were 80 members present.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The semi-annual meeting of the Society opened with a full program. Drs. Anthony Pino, of Bridgeton, and Paul M. Ware, of Shiloh, were proposed for membership. Drs. A. J. Thalheimer and Ada Walker, of Vineland, were elected to membership.

Dr. M. F. Sewall, a member of the State Society's Welfare Committee, reported its action with regard to the various proposed new bills to come before the Legislature.

After discussion concerning the recognition of specialists, a Committee of 5 was elected: Drs. M. F. Sewall, L. J. Kauffman, C. M. Gray, J. H. Winslow and E. C. Lyon.

The discussion on the "Costs of Medical Care" was introduced by a special communication from the President of the State Medical Society, Dr. A. Haines Lippincott, who, being present, began the discussion.

Dr. Fred J. Kalteyer, of Philadelphia, said he thought much of the *high cost* was due to extravagance in employing so many technical tests, many of them not pertinent to the disease under consideration. The doctors are depending too much upon these methods instead of employing the older methods for diagnosis. Many diseases of the respiratory tract could be treated as well at home as in the hospital. During *boom times*, people wanted everything, with private rooms and nurses; now, the wards are more popular but the costs for technical examinations remain the same.

The Public Relations Committee reported on the unlicensed practitioners, and those with limited licenses, who are exceeding the limits. Several have been cited to appear in Court for trial on January 26. The fines and punishment that have been already imposed on them do not deter them from continuing violating the law. A letter from the Secretary of the State Board of Medical Examiners was read, setting forth the methods used to inculpate the offenders and commending the physicians for their coöperation.

Dr. Fred J. Kalteyer, of Jefferson Medical College, discussed in a well prepared paper, with illustrations, the nervous mechanism of the parts involved and the differences between the symptoms of pneumonia and cholecystitis.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

An important project affecting the doctors and hospitals of Essex County is under way. It is called the "Hospital Service Plan" organized and advanced by the Hospital Council of Essex County, which Council is composed of: (1) 2 representatives of each hospital in the county, these delegates being the Executive and a member of the governing board; (2) the Directors of the Irvington General Hospital and the Newark City Hospital (who are the respective City Commissioners in whose department lies control of the hospital), the Directors of the County Hospitals for contagious diseases (Soho), mental diseases (Overbrook) and tuberculosis (Verona); (3) not more than 15 members at large representing the public interest; and (4) a member each from the County Medical, Dental and Nursing Societies.

To increase the revenues and help support the hospitals a plan has been devised to insure wage

earners against hospital charges for a 21-day period of illness in each year, at a cost of 85 cents per month. The Hospital Council, to effect the plan, has created a subsidiary body called the Associated Hospitals of Essex County, Inc.

The plan, as it now stands, is as follows:

In consideration of $10 a year, payable annually, semi-annually, or quarterly, or $ .85 per month, through voluntary pay-roll deductions, each payable in advance; the subscriber is entitled to participate in the benefits of the Hospital Service Plan of Associated Hospitals of Essex County, Inc. on the terms set forth below.

(1) The benefits hereinafter set forth are available to the subscriber immediately in the case of accident or emergency illness, and after 15 days from date of this contract in all other cases covered hereby.

(2) Any hospital with which Associated Hospitals of Essex County, Inc. has a contract for such services in force at the time hospital service is applied for hereunder may be selected by the subscriber.

(3) The subscriber shall receive hospital care in semi-private accommodations, i. e., the patient shall occupy a bed in a room designed to serve 2 or more private patients. If the subscriber prefers a single room, a credit of $4 per day will be given on the price of the room selected.

(4) Hospital care includes bed and board, general nursing care, routine laboratory examinations, emergency and non-ambulatory x-rays, operating room, routine medications and dressings, general anesthesia when such service is supplied by the hospital, and all other customary routine treatment which may be prescribed by the physician during the period of hospitalization.

(5) Such hospital care and service will be furnished up to and including 21 days in any contract year, on 1 or more admissions, provided the aggregate days shall not exceed 21. Additional service will be furnished to the subscriber at 1/3 discount off the regular hospital charges.

(6) *The benefits hereunder do not include services of the subscriber's attending physicians, surgeons, special nurses or their board.*

(7) Service will be rendered only upon authorization and request by the subscriber's personal physician, who must be a member of a County Medical Society in New Jersey and/or acceptable to the hospital selected by the subscriber. During the period of hospitalization the subscriber must be under the treatment and care of such physician in accordance with his staff privileges at the hospital selected by the subscriber.

(8) The services hereunder will end at the time the subscriber is discharged as a hospital patient by his personal physician, and the subscriber will be responsible to the hospital for payment of its regular charges for hospitalization after the date of such discharge.

(9) All service furnished hereunder is subject to the rules and regulations of the hospital selected by the subscriber. The benefits included hereunder cover only the treatment and care of illness and injuries regularly accepted for treatment by the hospital selected by the subscriber, and do not in any event include obstetric cases, those provided for by Workmen's Compensation, quarantinable diseases, mental and nervous disorders, or illnesses usually treated at other than general hospitals of Essex County.

If, at the time subscriber applies for such hospital service, the hospital selected is, in the judgment of its Superintendent, unable to furnish the required service, service shall be accepted in another of the hospitals designated.

No rights whatsoever shall accrue hereunder to any subscriber except for and during the period, whether annual, semi-annual, quarterly or monthly, for which the subscription fee has actually been accepted.

An explanation of the plan has been given to the public through the Newark Evening News.

Dr. William H. Areson, President, has announced the following organization of this society for the 1932-1933 period:

COMMITTEES

Ethics: A. W. Bingham, H. C. Barkhorn, J. H. Lowrey, W. H. Areson, E. W. Sprague.

Finance: W. H. Areson, Chairman, J. H. Lowrey, F. W. Pinneo, R. H. Rogers.

Publication: A. Charles Zehnder, Chairman, G. Blackburne, J. H. Lowrey, F. W. Pinneo, E. N. Riggins.

Nominations: J. H. Lowrey, Chairman, E. C. Klein, Jr., C. F. Rathgeber, A. E. Parsonnet, A. Stahl.

Credentials: H. Roy Van Ness, Chairman, John F. Condon, John D. Moore.

Membership: C. F. Rathgeber, Chairman, W. D. Crecca, G. W. Davies, E. Gennell, J. T. Hanan, S. C. Keller, E. L. Minard, J. D. Moore, L. H. Smith.

Milk: E. G. Wherry, Chairman; A. R. Bianchi, R. N. Connolly, T. W. Harvey, Jr., Arthur Heyman, Paul Hosp, Floy McEwen, R. H. Scott, W. H. Vail.

Maternal Welfare: J. N. Pannullo, President; W. B. Mount, Vice-President; E. W. Erler, Secretary-Treasurer; A. R. Bianchi, A. W. Bingham, R. J. Brown, Gus. A. Braun, B. A. Furman, Carl H. Ill, H. B. Kessler, R. T. Potter, N. G. Price.

Necrology: Floy McEwen, H. A. Tarbell.

Welfare: E. S. Sherman, Chairman; J. F. Hagerty, F. R. Haussling, J. B. Morrison.

Post-Graduate Instruction: H. H. Satchwell, Chairman; C. W. Barkhorn, J. I. Fort, B. A. Furman, W. B. Mount, Royce Paddock.

Formation of Associated Sections of the County Society: H. C. Barkhorn, Chairman; W. H. Areson, A. W. Bingham, R. N. Connolly, W. P. Eagleton, T. W. Harvey, Sr., F. R. Haussling, A. S. Kirkwood, C. R. O'Crowley, G. B. Philhower, B. B. Ranson, Jr., Wm. J. Runyan.

Woman's Auxiliary: Theo. Teimer, Chairman; Paul Hosp, H. Roy Van Ness.

Entertainment: Edgar A. Ill, Chairman; G. W. Davies, J. I. Fort, W. F. Grady, E. W. Sprague.

Control of Cancer: H. S. Martland, Chairman; Max Danzis, J. I. Echikson, Milton Friedman, F. R. Haussling, Edgar A. Ill, W. D. Miningham.

Study of Acute Poliomyelitis: E. L. Smith, Chairman; Chester R. Brown, R. N. Connolly, J. W. Gardam, R. J. Mullin, F. W. Pinneo, Warren Ripley.

Diphtheria Prevention: R. N. Connolly, Chairman; H. A. Tarbell, B. J. Smith, E. G. Wherry.

Illegal Practitioners: J. I. Fort, Chairman; R. N. Connolly, J. S. Lincoln, Edwin Steiner.

Hospitals: W. P. Eagleton, Chairman; J. F. Condon, Philip Conlon, Max Danzis, Wm. Gauch, J. F. Hagerty, F. R. Haussling, E. Z. Hawkes, Edgar Holden, F. E. Hubbard, Edgar A. Ill, Paul Keller, C. R. O'Crowley, A. E. Parsonnet, Guy Payne, E. L. Smith, Leonard Smith, A. F. Thompson, G. W. Vannatta, E. G. Wherry.

Periodic Health Examinations: D. A. Kraker, Chairman; F. A. Alling, H. N. Commando, W. D. Crecca, H. C. Crossfield. Chas. Englander, T. W.

Harvey, Sr., Edgar A. Ill, J. C. Mabey, O. G. Matheke, C. R. O'Crowley, F. A. Pringle, Warren Ripley, F. C. Weber.

Radio Broadcasting: Alfred Stahl, Chairman; D. A. Kraker, Geo. P. Olcott, E. W. Sprague, E. LeRoy Wood.

Compensation Board: D. A. Kraker.

Automobile Emblem: Alfred Stahl.

Ex-Presidents: E. J. Ill, 1896; T. W. Harvey, 1900; W. P. Eagleton, 1908; H. J. F. Wallhauser, 1911; E. Z. Hawkes, 1913; J. F. Hagerty, 1915; T. W. Corwin, 1918; G. B. Philhower, 1919; H. S. Martland, 1920; F. R. Haussling, 1921; A. J. Mitchell, 1922; C. R. O'Crowley, 1924; E. G. Wherry, 1925; Max Danzis, 1927; R. N. Connolly, 1928; A. W. Bingham, 1929; H. C. Barkhorn, 1930; J. H. Lowrey, 1931.

First Councilor District Meeting

Essex County Medical Society was host to the Annual Conference of the Counties of Essex, Morris, Union and Warren, constituting the First Judicial District of the State Medical Society, with Dr. C. C. Beling as Councilor. Dr. William H. Areson, President of Essex County Medical Society, opened the meeting and turned it over to the District Councilor, Dr. Beling, who in turn placed it in the hands of Dr. Frank H. Pinckney, President of the Morris County Medical Society. There was a large attendance; about 380.

Dr. N. B. Van Etten, of New York City, read a paper in which he analyzed the Final Report of the Committee on the Costs of Medical Care. (To be published later in the Journal.) Dr. Fred J. Quigley, of Jersey City, and Dr. J. B. Morrison, of Newark, discussed this paper.

Dr. John F. Hagerty, of Newark, spoke on "Specialism" and his remarks (see page 157) were augmented by Dr. E. G. Waters, of Jersey City.

Considerable gratification should be found in the report that members of the former Staff of the Hospital and Home for Crippled Children of Newark, resumed their position and duties at the hospital on January 1, 1933. All resumed their duties as before, with Dr. Elmer P. Weigel, of Plainfield, as Medical Director, nominated by them and appointed by the Board of Directors.

Dr. William H. Areson, President of the Essex County Medical Society, in his New Year's Message to the members, points out that the readiness and the ability of Organized Medicine to take the initiative in all matters of medical welfare and particularly in condemning the ignoring of the medical staff of a hospital in its medical management has been most ably demonstrated during the past year. The members of the former Staff of the Home for Crippled Children have resumed their staff positions. This is evidence of achievement possible only through unity in the organization. As a result of our successful outcome in this difficult situation, we enter the New Year at a moment when I feel that this Society has merited the confidence of our members and is thoroughly appreciated by all who are interested in organized medicine.

The past history of this significant controversy, between the lay Managing Board of the Hospital and the Medical Staff, can be found in an Essex County Society Report published in the Journal of the Medical Society of New Jersey, of January 1932, pages 89-91; and in an Editorial, entitled "Lay Control in Hospital Management", published in the same Journal, of April 1932, page 341.

Associated Physicians of Montclair and Vicinity

C. S. Kirkby, M.D., Reporter

October Meeting

The regular meeting of the Associated Physicians of Montclair and Vicinity was held on Friday evening, October 28, at the Marlboro Inn.

Dr. William H. Ross, Ex-President New York State Medical Society and President of Suffolk County (New York) Board of Health, the speaker of the evening, stated that the medical profession is undergoing a very rapid change. Its adjustment to new conditions might be more rapid than they are, but medicine is doing exceedingly well in overcoming many conservative traditions. The practice of medicine and the modern business demands are definitely different from what they were a decade ago. Medicine is a social function, and methods of distribution of services must go along with social changing conditions of the mass of people. There is a trend today toward fewer paying patients; growing fewer because other ways are provided to give them service. Social conditions limit people's capacity to pay for medical attention. The income of the physician is becoming less. Doctors in cities are no better off than doctors in small communities.

There are 3 points to bear in mind:

(1) To create harmony among all interests having to do with health.

(2) Aiding the public to distinguish between good and poor medical service, and to this end the public should be informed so that it can reap the benefits.

(3) Physicians should take a leading part in all health activities, like the Bar has taken in law. They should have a similar feeling in regard to their health and welfare, and at the same time to advance medicine.

When the present indifference to the confronting situation is overcome, the future of medicine will be brighter and more essential in human affairs than ever before.

Dr. H. C. Barkhorn, of Newark, discussing the paper, said he believed that the people want the best possible modern preventive and corrective medicine at a price within their reach. Professionals want to earn a livelihood without serious competition. All these changes in medicine are inevitably coming. They are going to be controlled by organized medicine, by the State, or by some corporation organized for pecuniary gain. Ethically, it is perfectly fair for labor to save money by using our services, but it is perfectly unfair for any lay organization to sell medicine and make money by sale of our services.

Dr. Barkhorn said that 75% of all patients get exactly what they need for their illness; 10% more get exactly what they need for their illness, but they do not think they do, and these are the noisy ones; about 15% need more work than we individually are able to provide them. This work is, usually, of a technical or a specialist type. The technical end of it will have to be provided eventually by semi-private hospitals, at a low service charge.

It is a well established fact that it is not the average patient who is complaining, but it is obvious that many changes are necessary.

November Meeting

The regular meeting was held on Tuesday evening, November 15, at the George Inness School. Invited guests of the Parent-Teacher Associations of Bloomfield, Glen Ridge, Montclair, Verona, Caldwell and Essex Fells were present.

Dr. Haven Emerson, President-Elect of the American Public Health Association, and Professor of Public Health Administration of Columbia University, College of Physicians and Surgeons, was the principal speaker. His topic was "Where the Parents' Job Ends and the School's Begins, for Child Health".

Dr. Emerson said that the duties of parents and schools necessarily overlap, but that each has its own particular responsibilities. The parents' job is, primarily, to see that the child is in fit condition to stand the stress of school life and to see that he is kept in good condition. To accomplish this there should be expert pre-natal care and expert medical guidance from the day of the child's birth. This is especially important during the first 2 years of life and should be carried on throughout the period of growth. The school's responsibility is to see that the school work is not damaging to the child's health; and that the child is not a hazard to his classmates. These safeguards are maintained by periodic health examinations and quarantine measures.

Dr. Emerson feels that chronic fatigue, as evidenced by irritability, inattention and failure to grow, is the greatest problem of the school child. The child normally avoids fatigue by alternate periods of play and rest, but this natural tendency is interfered with by any school routine. The schools are, however, gradually coming to realize this and are arranging their schedules accordingly.

Dr. Zachary, discussing the paper, stated that the schools have a very definite job in prevention of disease and maintaining good health habits.

Academy of Medicine of Northern New Jersey Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

January Meeting

The monthly meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, January 9, at 8.45 p. m.

Dr. B. M. Howley described 2 patients he had observed recently: The first, a child 5 weeks old, who had been operated on for cleft palate. When seen by Dr. Howley he presented a bilateral acute otitis media and a necrotic palate wound, and in the course of a few days developed edema and congestion of the lids, with exophthalmos, and died; the clinical diagnosis being cavernous sinus thrombosis.

Dr. Howley's second case report was that of a man first seen in April, 1932, 6 months after a perforating wound of the eyeball by a particle of steel, localized by x-rays 24 mm. behind the center of the eye and about 1-2 mm. above and to the side. He stated that there had been no inflammatory reaction and that he was considering an operation for removal of the traumatic cataract.

Dr. E. S. Sherman felt that it was likely that the foreign body had lodged on or in the sclera, rather than in the orbit behind the eye, and suggested removal by the magnet, if possible.

Dr. Russell Sherman did not think that Dr. Howley should be too optimistic about the patient's eye remaining free from inflammation, and cited the case which he had reported of a man with an undiagnosed intra-ocular foreign body which caused no inflammatory reaction until 18 months after the injury.

Dr. Lee W. Hughes described 3 patients, as follows: The first was a young man who showed a loop of connective tissue coming out from the side of the optic nerve into the vitreous and enclosing a blood vessel; and the condition was demonstrated before the meeting.

The second patient was a young man who had first noted poor vision 3 months before he was seen by Dr. Hughes, early in January 1933; weighing 245 lb. and showing other signs of glandular dysfunction. The visual field of the right eye was normal and that of the left showed only a part of the nasal field present. Radiograph of the sella turcica showed marked erosion, and confirmed the diagnosis of pituitary disease.

He described also a woman whose eye had been removed because of an advanced sarcoma of the choroid, which had extended to the outer surface of the globe. There was no sign of recurrence after 14 months.

Dr. Hughes read a paper entitled "Some Affections of the Iris and Ciliary Body, their Causes, Course and Treatment", in which he first reviewed the anatomy and physiology of the iris and ciliary body, and the etiology of inflammations of those structures. He then described the course of 8 cases of iritis or iridocyclitis, several of which were brought on by focal infections, stressing the importance of non-specific protein therapy, and mentioning "Omnadin" as a substance which he had found useful.

Dr. Howley, discussing Dr. Hughes' paper, pointed out the possibility of chronic infection in the intestinal tract, and asked if Dr. Hughes considered "Omnadin" superior to "Aolan". In reply to which Dr. Hughes stated that he was not aware that "Omnadin" was more efficacious than any of the other commonly used substances, but believed that it was freer of unpleasant side effects.

Dr. R. N. Berke read a paper on: "The Use of the Cross-Cylinders in Refraction". He traced the development of the cross-cylinder glasses and described the methods of use for the determination of both the axis and the amount of astigmatism. He considered the device of paramount importance in determining the axis, believing that for this purpose its precision was unequaled, but felt that while useful in determining the amount, it was not quite so dependable and was likely to lead one into error.

Both Dr. Hughes and Dr. Berke illustrated their remarks with lantern slides.

Adjournment at 11.15 p. m.

December Meeting

A clinical meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, December 12, at the Newark Eye and Ear Infirmary; the Chairman, Dr. E. A. Curtis, presiding, and 65 members and guests present.

Dr. Charles W. Barkhorn presented 4 patients showing the end-results of radical mastoid operations.

Dr. E. A. Curtis showed a man with optic nerve atrophy following an orbital injury by the end of a pot-handle.

Dr. Browne Morgan presented 2 ear patients:

1 with a bilateral fistula to the horizontal semicircular canal; and 1 who had a chronic mastoiditis with sinus abscess which had ruptured spontaneously into the mastoid. The causative organism in the latter case was Streptococcus mucosus capsulatus.

Following the presentations by Drs. Barkhorn and Morgan, there was considerable discussion of radical mastoid operations and infections by the Streptococcus mucosus.

Dr. Lyndon A. Peer showed 2 patients who were having scars, following burns on the neck, eradicated by skin grafts obtained from large tube-flaps on the back; also a case of atresia of the nostril repaired by a skin flap from the leg; and a fourth with extensive destruction of the tissues of the cheek and angle of the mouth, repaired by tube-flaps from the neck.

Dr. Edgar P. Cardwell described briefly the clinical course of a patient who died recently with a diagnosis of encephalitis. An encephalogram, showing air limited to the posterior fossa, and the post-mortem specimen, a large frontoparietal tumor, were also exhibited. The patient had shown no papilledema during life.

Dr. A. C. Zehnder showed a patient with the classic picture of retinitis circinata; and Dr. Russell Sherman showed a boy with a congenital paralysis of the superior rectus muscle and spasm of the inferior oblique of the other eye.

Dr. Lee W. Hughes presented 3 patients: one a child with congenital cataracts; the second a boy of about 12 showing old perforating scars of the cornea, iris and lens, but without any history of trauma: and the third, a man with a dense, central scar of the cornea resulting from an abscess, who obtained good peripheral vision after an optical iridectomy.

Dr. Dennis F. O'Connor presented a patient, 28 years of age, with an obscure fundus lesion. He stated that it was felt to be one of the cases of macular degeneration described by Dr. Arnold Knapp in 1929.

Dr. W. F. Krone showed x-ray films taken from a patient with an adamantinoma. This condition was discussed by Dr. M. C. Pearce and Dr. Ralph Pomeranz.

Several interesting conditions exhibited by bed patients were then demonstrated: sublingual carcinoma, by Dr. Henry B. Orton; cerebellopontine angle cyst with otitic symptoms, by Dr. Wells P. Eagleton; and otitic parietal lobe abscess complicated by tuberculous meningitis, by Dr. Richard Swain.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The Academy of Medicine of Northern New Jersey had as its Guest Speaker on January 19, Dr. Charles G. Kerley, of New York City, whose paper was entitled—"A Pediatric Symposium". Dr. Kerley's discourse was greatly enjoyed and his lantern slides were extremely interesting.

An amendment to the Constitution was adopted, permitting the admission of Junior Members (practitioners of less than 5 years' standing) at a fee of $5 per year.

The essayist for the next meeting will be Daniel Fiske Jones, M.D., F.A.C.S., of the Medical School of Harvard University, and his topic will be the "Treatment of Carcinoma of the Colon and Rectum".

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

December Meeting

Members of the Gloucester County Medical Society were addressed by Dr. William D. Stroud, of the Post-Graduate School of Medicine, University of Pennsylvania, at their meeting held in the Board Room of the First National Bank and Trust Company, on December 15.

Dr. Stroud gave an interesting illustrated talk on "Heart Diseases, With Special Reference to Treatment", which was followed by a general discussion of that topic.

Dr. H. B. Diverty, Delegate to the Camden County Association, and Dr. I. W. Knight, Delegate to Salem County, reported on meetings of these medical societies they had attended in the past month.

Following the meeting, members enjoyed a supper at the Homestead Coffee Shop.

Members present were William W. Pedrick, President, of Glassboro; B. A. Livengood, Swedesboro; Ralph K. Hollinshed, Westville; H. B. Diverty, Ralph Moore, Duncan Campbell, J. Harris Underwood, Fuller Sherman, and William Brewer, of Woodbury; Charles Pedrick, Glassboro; I. W. Knight, W. J. Burkett and M. F. Lummis, Pitman; C. I. Ulmer, Gibbstown; H. L. Sinexon, Paulsboro; E. R. Ristine, Westville; Black, Mickleton; Horace M. Fooder, Williamstown; Wilson Stout and Don Weems, of Wenonah.

Guests were Drs. William Stroud, Emma Richardson, Camden; and Oram Kline, Woodbury.

January Meeting

The regular monthly meeting of the Gloucester County Medical Society was held at the Oakwood Country Club on January 19.

Dr. Rehfuss, of Philadelphia, spoke on some gastro-enterologic problems of interest to the general practitioner, and augmented his talk with instructive slides.

A committee was named to investigate the question of the Costs of Medical Care and report findings at the next meeting. Members of the committee are: Drs. W. J. Burkett, R. K. Hollinshed, J. Harris Underwood, C. I. Ulmer and H. M. Fooder.

Members of the Auxiliary joined the Society at a buffet supper following the meeting.

A resolution of sympathy and flowers were ordered sent to Dr. Don Weems, of Wenonah, who is in the Underwood Hospital.

HUDSON COUNTY

Charles Sirken, M.D., Reporter

December Meeting

The regular monthly meeting of the Hudson County Medical Society took place on December 6, at the Carteret Club, Jersey City.

Dr. B. S. Pollak presented a majority report on the subject of approval, by the County Medical Society, of the North Bergen Municipal Clinic, which declared that this clinic should be approved, provided that no patient be treated in this clinic who has not received an order from the Overseer of the Poor of the Town of North Bergen, with baby welfare cases excepted. It stated that pre-natal work has no place in this clinic, as that is provided for elsewhere.

Dr. Maurice Shapiro submitted an amended minority report, as follows: "In view of the fact that a hospital exists in North Hudson accessible to all

in North Bergen, it is the opinion of the committee that no clinic is at present needed for the care of the indigent sick in North Bergen and we disapprove of the establishment of this clinic."

This amended minority report was accepted and adopted.

The Welfare Committee presented the following report on the Private Clinic in West Hudson—The Harrison Clinic—as follows: "The matter of the application of 2 physicians, to establish a private clinic in West Hudson, was discussed and the idea was disapproved by the Committee."

Dr. Haskins proposed the following resolution pertaining to this matter: "No private group of physicians is to adopt the name of a municipality. It is recommended that it use such a name as would indicate that they are a private group."

All of the above, relative to this Harrison Clinic, was seconded and carried.

Dr. Peter Maras gave a report of his observations while a member of a sub-committee of the National Committee on the Costs of Medical Care. He pointed out that reports were made by this Committee on types of medical practice in England, which were in vogue at the time this committee was first instituted, but which had since become obsolete. He also pointed out that the majority, by far, of the members of this National Committee, were Public Health officials, economists and doctors who were not practicing physicians and, therefore, in spite of their public spirited and philanthropic endeavors, could not properly represent the practicing physician.

A discussion followed and, as a result, the president was moved to appoint a Special Committee of 15 to study this question and report back to the society.

The scientific session was devoted to a paper on "Malignancy of the Colon", by Dr. W. Wayne Babcock, Professor of Surgery, Temple University, Philadelphia. An abstract of this paper follows: Carcinoma affects the large intestine frequently, and most of such growths originate in the rectum and sigmoid. Etiologically, there is an hereditary predisposition; age 40 to 60 years (3% below 20), male sex, and chronic irritated conditions of colon and rectum.

There may be progressively increasing constipation with recurrent abdominal cramps and visibly active peristalsis. Constipation is the usual symptom of involvement in the left half of the colon; progressive diarrhea, of the right half. Very significant is an apparently causeless morning diarrhea due to rectal carcinoma; arousing the patient between 5 and 7 a. m. Tenesmus indicates that the growth is close to the anus, while mucoid stools suggest papillary over-growth or mucosal irritation; offensive bloody stools indicate ulceration. The peculiar fetid odor, due to decomposing blood and malignant tissue, is considered by some proctologists pathognomonic of cancer. With cancer of the left colon, cachexia may be delayed for months.

Diagnosis. (1) History—One may be able to tell the place and type. (2) About 2/3 of the colon growths may be diagnosed by the examining finger, proctoscope, or sigmoidoscope. The deep ragged crater of the malignant ulcer; the craggy, raised, rolled and everted border; the infiltration into the wall of the bowel, are rarely mimicked by other conditions. (3) Carcinoma in or above the sigmoid, of large size, may occasionally be felt through the abdominal wall. (4) Radiographic study for growths higher in the colon.

Treatment. Radical excision gives a better prognosis than for cancer of any other part of the digestive track. For cancer of the proximal 2/3 of the colon, 2-stage, intraäbdominal resection and anastomosis is the preferred operation. For cancers below the midsigmoid a radical abdominoperineal extirpation is preferred. The perineal anus has been in disfavor, but with improved technic it may be made more satisfactory than an abdominal colostomy. For the slow low-lying rectal carcinomas, with slow infiltrative tendencies, a local excision through the enlarged anus may be adequate.

Th paper was discussed by Drs. Miner, McLaughlin and Perkel.

Special Meeting of December 16

A special meeting for the purpose of discussing the formation of a County Society Committee to function in connection with the "Plan for Accrediting Specialists and Controlling Specialism", was called to order by the President, Dr. Louis A. Pyle, at the Carteret Club on December 16.

A rather large and eager gathering listened for more than 3 hours to a battery of speakers who gave the *pro and con* on this subject, and we will attempt to give a brief summary of the arguments.

In Favor of the Plan

Dr. John F. Hagerty explained the origin and development of the plan to give the public information as to properly qualified specialists—to forestall vicious state legislation to regulate specialism; 3 such attempts having been made in our state. Plan was not "rail-roaded through". Dr. Waters read it 2 years ago. It was presented to the state Welfare Committee and Board of Trustees and approved by both. It was published several times in our State Journal; it was voted upon by the House of Delegates last year. It does not interfere with the legal rights of any regular licensed physician, and no one is compelled to seek endorsement. It will not prevent any doctor from doing any type of work he may care to—even without becoming certified by the State Society as a specialist. The names of those who fail of certification will never be made known.

Dr. Morrison: Plan will fore-stall action by the State Legislature. Preferable to National Boards—as it gives us under this plan a better line-up as to applicants' moral and ethical qualifications. The complexion of the Credential Committee is such as to make for fairness in judging applicants. Endorsement of this plan by our County Society is really unnecessary—the plan is already adopted.

Dr. Waters: It is our responsibility to protect the public by giving them properly certified specialists. Control of specialists has been undertaken in Italy, Hungary, Germany, Moravia, Vienna, Norway, England, Sweden, Alberta-Canada, Turkey and Belgium. There is no inhibition on general practice intended or attempted. As Dr. Reik has said: "Let us give moral support to those men whom we believe qualified to practice as specialists, and we can very well leave to the care of the public that man who says he is a specialist but who neither merits nor seeks the support of the State Society."

Perhaps this plan is not the acme of perfection, but it can be changed as may become necessary.

Against the Plan

Dr. Henry B. Orton, of Newark (the only Delegate who voted against the Plan at last Convention):

With applicants passed on by a committee of members who are not themselves specialists in the field to be examined, the plan amounts to "taxation without representation".

Dr. Chapman: The memberships of the various County Societies were unacquainted with this plan before its adoption by the State Society.

With 1 man out of every 5 a specialist, the plan would discredit the 4 men who are general practitioners. It would prejudice in a Court of Law the general practitioner who had done *special* work. The first question would be—"was this man accredited by the State Society". Establishes a bureaucracy—brother practitioner against brother specialist. Will relegate general practitioner to the background. Men will be unwilling to serve on credentials committee—due to close relationships with applicants. Specialists may use certificate in appealing directly to the public. Plan has not worked well in foreign countries.

General practitioner is perfectly competent to judge specialists. Our endeavors should be to discredit those that are not really specialists—not worrying about whom to accredit.

Dr. Reitnauer: We need *protection not control of* doctors. The Welfare Committee has been and will be capable in the future of taking care of Legislative bills. Individual honesty cannot be improved upon. Adoption of this plan will not prevent further legislative activity. Plan will not prevent any man from labeling himself "Specialist". Will open the gate for petty professional politics. "If you stand well—stand still."

Dr. Koppel: What about ¼ of the doctors of Hudson County who are not members of our Society. Patient will go directly to specialist instead of consulting general practitioner. Patient will determine what part of his body is at fault and will probably receive treatment from that particular specialist. General practitioner should be helped not restricted.

Dr. Kelley: The more local the control the greater the opportunity for politics to enter. No member of the State Board of Medical Examiners is willing to serve as a member of our State Credentials Committee of this plan. Plan would be biggest argument in the world for action by our State Legislature. Will do no good without a law to punish the man without a certificate. Hudson County has enough restrictions now and with a few more we might as well move out of the county.

Dr. Maras: Specialism is losing its popularity—why worry about it? Plan will not give bigger and better specialists to the public.

Dr. Woodward, Director Bureau of Legal Medicine and Legislation, A. M. A., states that plan does not affect legal rights of licentiate without a certificate and gives no method of penalizing such an individual—gives no procedure for a non-member making application—does not provide a procedure for a certified specialist who drops his membership. New York Academy of Medicine after 15 years effort on a plan finds a progressive decrease of supporters. In England, plan for control of specialists is heading for the rocks.

Drs. Hasking and Quigley both emphasized the fact that Societies were not devoting sufficient time to the transaction of their own business matters and that this particular plan should never have been passed without having been submitted to the individual memberships of the respective County Societies.

Finally it was regularly moved and seconded that the Hudson County Medical Soicety undertake the formation of the County Committee to accredit specialists in this county.

This motion was voted on but was not carried.

Dr. Quigley moved that the Board of Trustees of the State Society be communicated with promptly by our Secretary, stating this action, and requesting that the trustees postpone putting this plan into effect until the next Annual Meeting of the society.

Motion was seconded and unanimously carried.

January Meeting

At the general meeting of the Hudson County Medical Society, held at the Carteret Club on January 3, the speaker of the evening was Dr. Edgar Mayer, Medical Director of the National Vaudeville Artists' Tuberculosis Sanatorium at Saranac Lake, and the title of his paper was: "The Cavity in Pulmonary Tuberculosis, and Its Treatment". He classified the progress in cavity formation as follows: (1) Pre-cavity stage—sometimes a hazy, annular shadow. (2) Round, multiple holes, and no defense built up. (3) Round, sharply-defined rings with very little disease evident, and usually located in the infraclavicular region. About 98% of holes are dorsal and peripheral, so we often find pleural adhesions. Consequently, if you give an early pneumothorax, before adhesions form, you get a beautiful result. Dorsally, cavities nearer the apex; ventrally, cavities are lower. (4) Broader wall, but still there is elasticity, and it is collapsible. (5) Real rigid, and cavity with plenty of fibrosis. When there is rapid tissue destruction with cavity formation and very little outside tissue involvement, the question is—whether to *wait* and, perhaps, with the aid of serial radiographs, taken weekly, observe whether improvement follows. One thereby avoids pneumothorax therapy but takes a chance on fibrosis or the formation of adhesions. With excellent judgment, a physician may be able to tell whether he can afford to wait, or had better begin air treatment. The *medical man* should tell the *surgeon* what to do in lung surgery.

Rib resection should be done from above downward. More than 90% of patients with cavities have positive sputum. Phrenicectomy is done for adherent uncollapsed cavities.

The paper was discussed by Drs. Pollak, Jaffin, Bortone, Potter, Dodson, and Pearlstein.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

December Meeting

The Mercer County Medical Society met in the Carteret Club on December 14, for its Annual Meeting, President Wilbur presiding.

The minutes of the preceding meeting were read and approved, after which the Treasurer's report was submitted, and Drs. Blaugrund, Harman and Vanneman appointed as an Auditing Committee; this Committee later reporting the books of the Treasurer to be in due and regular form.

Resolutions on the death of Drs. Armstrong and Higgins, were read and adopted.

Communications were read from: Dr. R. G. Leland, Director, Bureau of Medical Economics, American Medical Association; from Essex County Medical Society; the Committee on the Costs of Medical Care; Dr. Cosgrove, relative to the appointment of a Committee on Post-Graduate Lectures. They received due consideration in the appointment of committees by the incoming President.

Drs. Charles C. Cohen, William Cohen, E. W.

Burroughs, N. H. D'Gianni, Robert Forer, G. F. Hutchinson, B. B. Scasserra, and Benjamin Salway were elected to membership.

The names of several new Applicants were read and referred to the Membership Committee.

Relative to certain amendments to the State Society By-Laws, a Committee will be later selected by the President to amend the County Society By-Laws.

The request of President Lippincott, for the appointment of a County Committee to act in conjunction with the State Committee on Accrediting Specialists, brought forth considerable discussion, which was enlivened by the presence of Dr. J. B. Morrison, who very kindly consented to enlighten the members, and explain the plan in concise language; following which, the motion was carried unanimously that such committee be appointed.

Following the announcement by the President that the next order of business would be the election of Officers, the resignation of Dr. Wilbur Watts, Vice-President, was read, and, with many expressions of regret the resignation was accepted.

The following Officers were duly nominated and regularly elected:

President, Francis E. Proctor; Vice-President, John A. Connelly; Secretary-Reporter, A. Dunbar Hutchinson; Treasurer, Harry R. North; Censor, R. B. Seely; Member of the Nominating Committee, State Society, Harry R. North; Alternate, D. L. Haggerty; State Delegates, C. F. Adams, D. L. Haggerty and J. J. McGuire; Alternates, W. E. D'Arcy, William L. Wilbur, B. D. Lavine, J. F. Pessel, J. H. McCullough, Samuel Blaugrund, R. J. Cottone, N. B. Oliphant, C. R. Sista, J. M. Schildkraut.

President McKiernan of the Middlesex County Society, being present as the Guest of Councilor Scammell, was called upon, and finished his remarks by extending an invitation to the members to attend its next meeting to be held at the Woodrow Wilson Hotel, New Brunswick, December 21, at 8.30 p. m. The Speaker on this occasion will be Dr. Lewellys F. Barker, Professor Emeritus of Medicine, Johns Hopkins, who will speak on the subject—"Preventive Medicine from the Standpoint of the Internist; Its Value to Public Health".

January Meeting

The Mercer County Medical Society met in the Carteret Club on January 11, with President Proctor presiding. Following the call to order, the President granted the privilege of the floor to a representative of a Collecting Agency, who explained in detail their system.

Drs. Herman Cohen, H. D. Cowlbeck, A. D. Guglielmelli, P. J. Finegan, J. R. Harman, Vartan Kachdorian, G. H. Miller, T. V. J. Mitskas, C. L. Marotte, Joseph Ragany were regularly elected Active Members, and Dr. John T. Dimun an Associate Member.

The Secretary read a communication from the Editor, Dr. Reik, relative to matters which would appear in the January Journal, and emphasized the importance of reading *every* monthly issue of our Journal in order to obtain authoritative information that will enable each and every member to formulate his own definite conclusions, create new opinions, to judge with intelligence and to talk understandingly of current affairs. Dr. Hutchinson urged reading the Journal habitually because the Editor cannot *always* call attention to important news articles appearing therein.

Attention was called to the recent action of the State Society relative to *Associate* membership, and a motion was made and regularly carried, that such trial period memberships be limited to 2 years.

Dr. Child, of the City Health Department, presented a recently developed diagram, of a comparative nature, showing the varied mortality rate in early infancy.

Considerable discussion arose in criticism of an apparent discrepancy in the chart which placed the City of Trenton, with its several reputable practitioners and excellent Department of Health, in a most unfavorable position. It was later voted that Dr. Child be asked to bring to the next Society meeting certain information regarding the conclusions upon which the diagram was formulated.

The President announced that the personnel of the Committees on Program, Membership, Post-Graduate Courses and Medical Cost will be named in the near future.

MIDDLESEX COUNTY

Samuel Gordon Berkow, M.D., Reporter

The regular meeting of the Middlesex County Medical Society was held November 30, at 9 p. m., at Pfaff's Restaurant, Metuchen, with Dr. Robert L. McKiernan presiding over 30 members and guests.

Communications from Hudson and Mercer Counties were read. These related to Dr. Waters' Plan for accrediting of specialists and controlling specialism as adopted by the State Society. The communications indicate a desire to review this matter.

The Secretary reported that at the Annual Conference of County Society Secretaries and Reporters he had been informed that the County Committee on Specialism should be elected for a period of one year, not for a longer period, as seemed mandatory from our original reading of the *plan*. On motion by Dr. Wilentz, a County Committee on Specialism, elected at the previous meeting, will serve for a period of 1 year.

The Hudson and Mercer communications were discussed by Drs. Hoffman, Silk and Nafey. The speakers advised against precipitate action, and it was agreed that no action should be taken at present.

A communication was received from the Essex County Medical Society, summarizing action: of the Medical Staff of the Hospital and Home for Crippled Children of Newark; of Essex County Society; and the State Society; on the share of Medical Staffs in hospital management and the ethics of individual members in relation hereto.

Communication from Dr. Frank G. Scammell, Councilor of the Third District, announcing arrangements for a Councilor District meeting; to be held December 7, at the Johnson & Johnson Factory, New Brunswick. All members of the Society were urged to be present.

A communication from Dr. Henry O. Reik, Editor of the State Journal and Executive Secretary of the New Jersey Medical Society, called attention to an error in the published report that the fee for the Rutgers-State Society courses this year would be $30. Dr. Reik states that the fees will be the same as they were last year—$15 for the first course subscribed to and $10 for each additional course taken, regardless of where the additional course or courses may be presented.

Dr. Nafey reported for the Ethics Committee, that the proposed amendment, creating Associate

Membership, has been revised in conformity with the Essex County Society's plan, as follows:

"An applicant for membership eligible under the Constitution, whose license and registration in New Jersey are within 2 years of his application, shall be admitted to Associate Membership. The obligations shall be the same except as dues to the State Society are modified by that Society. The privileges shall be the same but without power to vote or hold office, and the term of such Associate Membership shall automatically expire, by limitation, after 2 years."

On motion by Dr. Silk, seconded by Dr. Wilentz, the report of the Committee was accepted.

Dr. Nafey reported favorable action on the following applicants for membership: Dr. Samuel Breslow, of Perth Amboy; Dr. Fred Taybor, Dr. Estelle Kleiber, and Dr. J. E. Sandella, of New Brunswick. The Ethics Committee also approved the transfer of Dr. S. Fox, of Fords, from the Philadelphia County Medical Society.

On motion by Dr. Henry, Jr., the report of the Ethics Committee was accepted.

Applications from Dr. Dorothy Marvin, of New Brunswick, and Dr. Fannie Sender, of South River, were read and given to the Ethics Committee.

The application of Dr. S. M. Lazow, of Matawan, requesting a transfer, was returned from the Ethics Committee with the advice that the applicant should go to the Monmouth County Society, which Society may release him to us if his reason for requiring such a transfer is satisfactory.

The application of Dr. C. H. Rothfuss, of Woodbridge, which had been referred back from a Special Committee to the Medical Ethics Committee, was reported favorably by Dr. Nafey.

Discussion by Drs. Spencer, J. V. Smith, Henry, Jr., and Wetterberg indicated their dissatisfaction with the procedure adopted in this case. The appointment of a Special Committee, to replace the Ethics Committee, was criticized as showing a lack of respect for and confidence in, the probity of the Ethics Committee; and as a dangerous precedent.

After a somewhat heated discussion this application was referred back to the Ethics Committee, on motion by Dr. J. V. Smith.

Dr. J. V. Smith reported for the Post-Graduate Study Committee, and thanked the members for the response of the past year. New course will consist of 6 weekly lectures of 2 hr. each. As a member of the State Society Committee on Post-Graduate Work, Dr. Smith was able to outline the courses of study for the new term, and showed their fine quality and value to the profession.

The Secretary read a letter on the Cost of Medical Care. On motion by Dr. Henry, Jr., action was delayed until a full report is available.

Dr. McKiernan suggested an amendment to the Constitution, creating an Advisory Committee, to consist of Past-Presidents of the County Society. The proposal was still-born; the result of craniotomy by Dr. J. V. Smith.

Dr. McKiernan reported that he had obtained Dr. Lewellys F. Barker, of Johns Hopkins University, as prineipal speaker for the Annual Meeting, which will be held on December 21, at the Hotel Woodrow Wilson, New Brunswick. This announeement met with an enthusiastic reception.

Dr. McKiernan appointed the Nominating Committee, as follows: Drs. W. E. Sherman and Marshall Smith, of New Brunswick, and J. J. Mann, of Perth Amboy.

A collation was served after adjournment.

MONMOUTH COUNTY

Harold A. Kazmann, M.D., Reporter

November Meeting

The regular meeting of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital on Wednesday, November 30, with Dr. Stanley Nichols presiding.

The Reporter presented a talk on the Annual Conference of County Society Secretaries and Reporters, held in Trenton, November 2.

The question of certifying specialists was held over for discussion at a subsequent meeting.

An amendment to the Constitution, to change the place of the Annual Meeting, was read and tabled until the next meeting.

A report of the Committee on Medical Costs was presented by President Nichols and discussed by several members of the society. A fuller presentation of this important topic was promised for the next meeting, which will be the 116th Annual Meeting of the Monmouth County Medical Society.

The papers of the evening were: "Clinical and Hematologic Observations on Agranulocytosis", based on a study of 50 cases, presented by Dr. Mason Rosenthal, of the Mt. Sinai Hospital, New York; and, "Recent Advances in the Treatment of the Anemias", by Dr. Hyman I. Goldstein, of the Philadelphia General Hospital. These were fully discussed by numerous members of the society.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The Morris County Medical Society held a regular quarterly meeting the evening of December 15, at the New Jersey State Hospital at Greystone Park. Notwithstanding the none-too-inviting traveling conditions, President Pinckney had the pleasure of presiding over a very good attendance of some 55 members and guests; among the latter being 2 representatives of Sussex County, Dr. Morrison, of Newton, and Dr. Aiken, Resident Surgeon of Newton Memorial Hospital.

Routine business included the election of 4 new members: Walter J. Kossmann, of Pompton Plains; Carmelo Musetto, of Boonton; Harold R. Scott, of Morristown; and Hilmar R. Schmidt, of Lincoln Park.

The scientific chapter of the meeting was presented by Dr. William Darrach, Professor of Surgery at the College of Physicians and Surgeons, Columbia University, his subject being "The Modern Treatment of Fractures".

The speaker covered his subject in a direct conversational style that impressed many important points; stressing careful, gentle and thorough examination; the advantage of featuring the patient within the shortest possible time after the fracture; the damage done to the soft surrounding parts by improper first aid; the importance of attention to the soft parts, damage of which may be more important than the fracture itself with the interference of blood supply, etc.; citing the importance of the Thomas splint, in a case where it was used on the athletic field where the injury occurred and making complete unity and recovery in 7 weeks, as against another exactly similar injury in a similar game, where the one injured was encouraged to try to use the leg, then carried with the leg dangling, placed in a taxi and brought to the hospital, in which it took 7 months for recovery; stressing the importance of immediate x-ray picture to see just what the condition is and

just what is to be done to avoid further damage to surrounding tissue and soft parts; citing groups that do not respond to treatment because of conditions such as diabetes, arteriosclerosis; and some who just do not form bone; reminding that as injury is the cause of swelling, immediate treatment is important though against the old theory of waiting for the swelling to subside.

Dr. Darrach covered his subject at length and in much detail, both interesting and refreshing to his attentive audience.

Various questions were answered by the speaker after discussion which was entered into by Drs. Costello, Williams, Rice, Thomas, Frost, VanBuren, Rubin, Haven, Lathrope, Teskey and Pinckney.

After adjournment, refreshments were enjoyed in the employees' cafeteria of the institution.

OCEAN COUNTY

Eugene G. Herbener, M.D., Reporter

The Ocean County Medical Society held its Annual Meeting at Murray's Log Cabin, Lakewood, November 21, at 6.30 p. m.

President Blackwell Sawyer sent a message requesting Dr. Abraham Goldstein to preside in his stead, as he was unable to attend. There were 15 members in attendance. Regular routine business was transacted. Treasurer Frank Brouwer rendered his report, which showed a substantial balance in the treasury. It was received with thanks.

The report of Drs. Alfred Woodhouse and Eugene Herbener on the Annual Conference of Secretaries and Reporters, concerning the guidance of Specialists, was discussed by all present.

The election of officers for the ensuing year then followed: President, Abraham Goldstein; Vice-President, G. H. Swan; Secretary, A. Woodhouse; Reporter, E. G. Herbener; Annual Delegates, V. M. Disbrow, E. F. Thompson, Abraham Goldstein, Frank Denniston. It was moved and carried that the Secretary cast the ballot for the above named candidates.

The Secretary read applications for membership: W. S. Hayden and F. Lehmacher. It was moved and carried that, that committee having reported favorably, a vote be taken, which resulted in unanimous election.

We had a lengthy discussion about matters pertaining to the society, reserving decision for our next meeting to take place one month from date.

A discussion of interesting cases followed, with all members present expressing their willingness to render suitable services to all those suffering from the economic depression.

PASSAIC COUNTY

Wayne W. Hall, M.D., Reporter

December Meeting

The regular meeting of the Passaic County Medical Society was held at the Health Center, Paterson, Thursday evening, December 8, at 9 p. m., with Dr. Roemer presiding.

The Treasurer's Report for the year was presented by the Secretary and approved as read.

The report of the Board of Censors was read, and 29 Members and 5 Junior Members were elected. Their names being as follows: Arthur Andrew Allen, Abraham Herman Apter, Frank A. Barlow, Charles B. Bromberg, Edward A. Cappola, Harry Dawson, Arthur Winter Hambright, Stephen G. Holster, Albert G. Jahn, Burton O. Kinney, George Koerber, Elias David Lawrence, Herman Levy, George Logan McCarthy, Francis R. Meyer, Dennis Martin O'Brien, Manasseh Benjamin Park, Nicholas F. Scielzo, Dean Anthony Wry, M. Franklin Bireley, Austin Morris Curtis, Armand De Rosa, James S. Gallo, Clifford M. Gordon, Elias J. Hatem, Herman Harold Holt, Abraham Kovin, J. P. Kuhl, Henry Eugene Reading, Herman B. Ring, Roy R. Schubert, Elroy Willis Smith, Raymond R. Stoltz, Israel Judah Wolf.

Dr. Mitchell moved, and it was seconded, that the memberships become effective January 1, 1933, upon condition that dues are paid.

A resolution regarding Dr. Thomas A. Dingman's death was accepted by the Society, a copy of which will be spread upon these minutes and one of which will be sent to his bereaved family. (See Obituary Department in this Journal, page 196.)

Dr. John S. Yates presented a most painstaking report on "Medical Advertising". He cited Bergen and Hudson Counties as pioneers in this form of advertising, stating that they have not, apparently, found it materially beneficial. Dr. Yates' Committee concludes that we should not undertake an advertising program; it being expensive and evidently unfruitful where-ever it has been tried.

Dr. Morrill moved, and it was seconded, that the Committee be commended and the report accepted.

Dr. Marsh moved, and it was seconded, that a committee of 5 to 9 members be appointed to study the Report on the Costs of Medical Care.

The motion was adopted and the membership of that Special Committee will be announced later.

The Scientific Program consisted of a paper on the "Treatment and Diagnosis of Nephritis and Nephrosis". The paper was presented by Dr. Walter Niles, Professor of Medicine, Cornell Medical College, in a most interesting and instructive manner. It was discussed by Drs. Bergen, Levinsohn, Polowe, Ryan and David Shapiro.

There were 79 members present. The meeting adjourned at 11 p. m.

January Meeting

The regular monthly meeting of the Passaic County Medical Society was held at the Health Center in Paterson, Thursday, January 9, with Dr. Bergen presiding.

The regular business was dispensed with because the Guest Speaker of the evening had to leave early.

Dr. Martin Rehfuss, Professor of Medicine, Jefferson Medical College, Philadelphia, presented an interesting and instructive paper on: "The Medical Treatment of Gall-Bladder Disease", covering that topic in a masterly manner. He strongly recommended the low-cholesterol diet, and revealed the fact that of 1000 patients treated medically, only 56 required later surgical care.

Considerable discussion was stimulated; those members participating being Drs. John Carlisle, Jacob Roemer, and David Polowe.

Adjournment took place at the end of the Scientific Program.

SALEM COUNTY

William H. James, M.D., Reporter

The meeting of the Salem County Medical Society was held at the Memorial Hospital, Salem, Wednesday, December 14, at 9 p. m., with 18 members and guests present. The guests included Drs. Glover and Clements, of Camden County; Aiken of Cumberland County; Knight, of Gloucester

County; and Dr. Suter who recently moved to Pennsgrove to take over the practice of the late Dr. Robert Jarrett.

The regular business of the Society was conducted in the usual manner, after which Dr. R. M. A. Davis read a very interesting paper on "Tonsillectomy", giving a résumé of over 1000 cases. The best results were obtained by general anesthesia and use of the snare; hemorrhage occurred infrequently and upon such occasions was controlled by ligature and the use of adrenalin solution. The best time for removal of hypertrophied tonsils, other things being equal, is between the ages of 2½-4 years, because, if disposed of at that time, you will prevent the child developing into a mouth breather. The paper as a whole was very interesting and instructive throughout, and was discussed by Drs. Green, Church and Fleming.

Dr. Dunn had attended a meeting of the Essex County Medical Society and gave a very interesting account of a paper read before that society entitled "Nephritis in Pregnancy". The author said that nephritis in pregnancy was different from eclampsia and the best treatment for nephritis in pregnancy is abortion.

After the meeting was adjourned, a collation was served in the main dining room of the hospital.

SUSSEX COUNTY

F. P. Wilbur, M.D., Secretary

The Sussex County Medical Society held its Annual Meeting at the Cross Roads Inn, Ross' Corner, December 15. The minutes of the last meeting were read and approved.

Dr. D. L. Spurgeon, of Newton, was elected to full membership.

The Plan for Accrediting Specialists: After full discussion of this subject, it was moved and seconded that Sussex County Medical Society go on record as endorsing this plan. The following committee for carrying out the plan in Sussex County is as follows: Drs. Leo Drake, Ogdensburg; Joseph G. Coleman, Hamburg; Blase Cole, Newton; Warren H. Smith, Newton; F. P. Wilbur, Franklin.

A copy of the resolutions on hospital management of the Essex County Medical Society was read.

The letter from the Committee on the Costs of Medical Care was read and referred to the County Welfare Committee.

The county society dues were fixed at $1.

Officers were elected for the ensuing year, and dues collected.

The meeting then adjourned.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

A largely attended meeting of the Society was held at the Elizabeth General Hospital on the evening of January 11, with Dr. Emil Stein presiding. The regular order of business was suspended and the guest speaker introduced. Dr. John F. Erdmann, Professor of Surgery at Columbia University and the New York Post-Graduate Medical School, spoke on "The Recognition and Treatment of Post-Operative Complications". His interesting and comprehensive talk was followed by a general discussion.

The following physicians were elected to membership: Drs. Lewis H. Jones, Roselle Park; Roman Schweizer, Francis J. Cronin, Carl G. Knapp, and Meyer A. Fiecter, of Elizabeth; Franklin C. Young, Summit; and Dr. E. Milton Staub, of Westfield.

Following the meeting, refreshments were served and a social hour enjoyed.

Obituaries

Resolutions Adopted by the Somerset County Medical Society on the Death of Dr. George Lewis Mack

On January 16, 1933, one of our most esteemed and faithful members died of heart disease. He had been ailing for the past year or more but was confined to his bed for only the last month of his life.

Dr. Mack was born in Perth Amboy, on July 4, 1881, the son of George W. and the late Frances Wood Mack. He received his elementary education in the schools of Perth Amboy. His medical degree was received at the Baltimore College of Physicians and Surgeons—now merged in the University of Maryland Medical School. After graduation, in 1907, he served an internship in the Elizabeth General Hospital, and then engaged in general practice in Freehold, in 1910, where his stay was short because he preferred Bound Brook for a permanent home.

In Bound Brook he established a very successful practice and at the same time lent himself freely to municipal affairs. He was admired by his fellow practitioners and patients for his integrity, high principles, honesty and judgment. He served on the Borough Council for 6 years, and was also President of the Chamber of Commerce and of the Exchange Club for many years. As a member of the Eastern Star Lodge, 105 F. and A. M., he was always actively interested in fraternal work in this district. He was President of the Square Club at one time, and was a member of So-Ra-Bo Forest, Tall Cedars of Lebanon, Raritan Valley Aërie, No. 2013, F. O. E. Somerville, Presbyterian Church in Bound Brook and the National League of Masonic Clubs.

At the last Annual Meeting of the Somerset County Medical Society, Dr. Mack was elected Vice-President for the year 1933. He was on the Staff of Somerset Hospital, was local surgeon to the Lehigh Valley, Reading and C. R. R. of N. J. and also was County Physician. As County Physician, he had served since 1926 and only a week before his death was sworn in for his third term.

A special meeting was held on January 18 when a Resolution Committee was appointed, and the following resolutions drawn up:

Whereas, because of his faithful and conscientious following of the duties of his chosen profession, and because of his active participation for many years in the work of this Society, and because of his Christian character and loyalty to his fellow practitioners; therefore, be it

Resolved, that we, the members of the Somerset County Medical Society, express our sorrow over the loss of a faithful member and an upright citizen in the community; and be it further

Resolved, that these resolutions be sent to the bereaved family, be published in the local press and in the State Medical Society's Journal, and be spread upon the minutes of this Society.

Alfred F. W. Sferra
Lancelot Ely
Morris Borow
Committee

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DISPENSARY PLAN OF THE CLEVELAND ACADEMY OF MEDICINE

New Principles for Admission to Dispensaries

(a) All social agency workers agree to refer all cases which, at one time or another, have been under the care of a private physician, back to that physician. No time limit is to be applied to this principle.

(b) It is agreed that all other persons who now or ultimately might be able to pay something should be referred by the social worker to a neighborhood physician.

(c) The out-patient departments of all the hospitals agree, through their social service departments, to follow the 2 courses of action outlined above.

Application of Principles

(1) The plan is to be applied to new admissions only (i. e., cases not under treatment by dispensaries at time this plan is inaugurated).

(2) To handle the "traffic" and other problems inherent in the plan, there should be a Central Committee composed of representatives of the major groups involved, to which individual problems can be presented by the social worker, the patient and the physician; and by which modifications of the plan, if the need arises, may be recommended.

(3) From the questionnaires which have been returned to the Study Committee the Academy will compile lists of physicians who are willing to cooperate in the plan. These lists, together with the names, addresses, telephone numbers, specialties and office hours, will be supplied to the social agencies.

(4) Where there is no family physician to whom the patient will return, the agency worker will ask the patient to select a physician from a list.

(5) The Central Committee will supply to all agency workers a conveniently sized pad of forms in triplicate with carbons to be used as referral slips. The slips shall contain place for the name and address of the patient, the name and address of the doctor to whom the case is referred, the name and address of the agency and of the worker making the reference. At the bottom of the slip shall be a line to be filled out by the doctor if he does not keep the patient, but refers him on to a dispensary.

(6) The worker shall give the patient one slip to take to the doctor; shall send to the Central Committee the second slip; shall keep on file with the agency the third slip. An individual number shall be printed on each set of slips for identification purposes and if possibe agencies referring the larger groups shall have distinct colors for their slips for easy identification in filing.

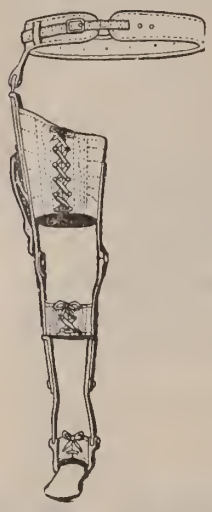
(7) The patient shall take the slip to the doctor, who will then proceed as follows:

(a) He will treat the patient for such fee as he and the patient agree is fair, or

(b) He shall treat the patient free or on a deferred payment basis, or

(c) He shall refer the patient to a dispensary (filling out the line at the bottom of the slip and giving it back to the patient to take to the dispensary).

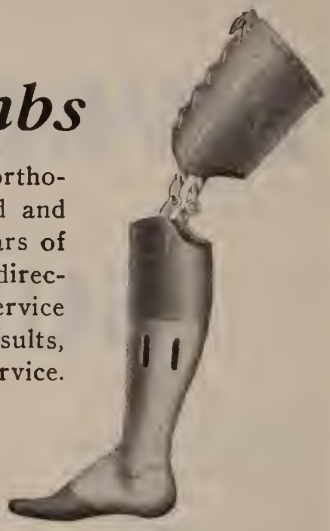
(8) Dispensaries receiving patients with slips shall send these slips to the Central Committee for filing with the corresponding slip mailed in by the referring agency.



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DIGITALIS IN HEART FAILURE

In Maine M. J., Sept. 1931, Dr. Paul D. White, of Boston, asserts that life can certainly be prolonged and made more useful and happy by restoring and maintaining with digitalis the tone of the heart muscle which has begun to fail, whether or not the heart rhythm is normal. It is a wonderful drug, and even without rest, may restore normal heart function. Of course, it must be given in the proper dosage.

"The administration of digitalis is still the most important measure of all in the treatment of moderate and marked degrees of congestive heart failure. It can be given rapidly by mouth or intravenously or intramuscularly. If there is not extreme urgency, a satisfactory plan for rapid digitalization is to give 2 pills or tablets, of 1½ grains of digitalis leaf each, 3 times a day for 2 or 3 days, or 3 such tablets 3 times a day for 1½ to 2 days (that is, for 5 or 6 doses).

Sometimes proper rest and digitalis are not sufficiently effective to dispel congestive failure and edema. It is then that one should turn to diuretics. The salts, like ammonium and calcium chloride, are hardly worth using, except infrequently as adjuvants to more potent diuretics. The purine diuretics, theobromine and its allies, are often effective. The most satisfactory member of this series I have found to be theobromine-calcium salicylate or Theocalcin, given in the dosage of 15 grains (2 7½ grain tablets) 2 or 3 times a day for a few days at a time or longer."

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FOUNDATION GRANTS SHOW 23% DECLINE

(Newark Evening News, Dec. 27)

More than half of the $54,600,000 given away by 102 American philanthropic foundations in 1931, $29,643,000, came from the Rockefeller fortune, the annual survey of the Twentieth Century Fund revealed. Medicine and public health received $17,144,000, education $13,579,000. Social science and physician science, third and fourth with $5,832,941 and $4,667,000, respectively. Prohibition received $100, the smallest amount of the 27 fields represented.

Ninety-one foundations reported for 1930 compared with 102 for 1931; but according to the survey, "foundation grants appear to have declined 23.7% in 1931, compared with 1930; this decline is about in proportion to estimates of the reduction in the national income as a whole during the same period, which is put at 20 per cent."

Although the Rockefeller group was the largest giver in 1931, as it was in 1930, the Carnegie group had the largest capital resources. The capital of the Rockefeller group, as shown in the report, is $198,000,000, while the Carnegie group has $246,000,000.

Besides the Rockefeller and Carnegie disbursements which together accounted for a 70.8% of the annual national philanthropy, other large foundations include:

Duke Endowment, $3,754,000.
Julius Rosenwald Fund, $2,367,000.
Wyomissing Foundation, $1,130,000.
Children's Fund of Michigan, $871,000.
Commonwealth Fund, $847,000.
Milbank Memorial Fund, $823,000.
Murry and Leonie Guggenheim Foundation, $401,000.
Russell Sage Foundation, $387,000.

THE RIGHTS OF THE MEDICAL PROFESSION

(The Weekly Roster and Medical Digest)

(1) Services rendered by individual physicians in the aggregate constitute the great bulk of all medical service; therefore the profession asks for its practitioners freedom of opportunity to develop to the limit all their individual capacities.

(2) It asks a career of independence under conditions of free and dignified competition.

(3) It asks remuneration sufficient for costs incidental to constant change in equipment for medical practice, both material and intellectual, and for reasonable comfort for the physician and for his family.

(4) The medical profession offers its history of altruism and capacity to serve as justification for its claim to control its own affairs.

Walter F. Donaldson, M.D.

HONORS STRICKEN DOCTOR

(New York Times, Jan. 7)

Dr. Walter Blair Stewart, Jr., was named today as the "outstanding citizen for 1932" and winner of the annual "Good Deeds" award of the Atlantic City Kiwanis Club. Dr. William H. Carrington, head of the club, said that the physician had been chosen because of his "tireless and efficient" efforts in fighting infantile paralysis here last Summer.

Dr. Stewart, who was in charge of the poliomyelitis work at the Municipal Hospital for Contagious Diseases, was stricken with the disease and was in a critical condition for weeks. He is convalescing now. His 2 children, Blair, 3, and Florence, 18 months, also stricken, have recovered.

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Journal of the Medical Society
of New Jersey

Gentlemen: In the final analysis, all business is a profession of faith. It begins with the faith of an individual; it establishes faith among those with whom it has commercial relations. It builds up and reciprocates the faith of its employees. It looks ahead continually with faith and confidence in the future.

It is with this thought in mind as we are starting the New Year that we make known to you our appreciation for your good will and coöperation during the trying year just closed and express to you our sincere wish that the year ahead will justify in a large measure the faith that we have and that we hope that you have, and that is so essential to the return of sound business growth and prosperity.

Very truly yours,
Eli Lilly and Company
John S. Wright, Director
Advertising Department

HOSPITAL BOARD ELECTS

(Newark Evening News, Jan. 13)

Officers were elected at the Annual Meeting of the Medical Board of St. Michael's Hospital held yesterday at the hospital. Those elected to serve for 1933 were: President, Dr. William Petry; Secretary, Dr. George Blackburne; Treasurer, Dr. Samuel B. W. Leyenberger; and Executive Committee, Drs. Joseph L. Fewsmith, Edgar Ill and J. Irving Fort.

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One of the oldest private boarding schools of its kind in the United States, provides unsurpassed facilities for exceptional children. The School maintains winter quarters in New Jersey, and a summer camp on the coast of Maine. It is an incorporated body, operated "not for profit," and controlled by a Board of Trustees, whose aim it is to offer the highest type of scientific training and intensive education attainable. It has a competent corps of nurses, a resident physician and a medical staff of national reputation; organized to give the fullest possible cooperation to physicians, whether they wish to retain medical supervision of patients enrolled in the School, or prefer to delegate both treatment and training to the School staff.

ILLUSTRATED CATALOG ON REQUEST

BOX 380, HADDONFIELD NEW JERSEY

HONORS DR. SCHICK FOR MEDICAL WORK

(New York Times, Jan. 3)

Dr. Bela Schick, pediatrician at Mount Sinai Hospital and originator of the test for susceptibility in diphtheria diagnosis which bears his name, received the gold medal of the Phi Lambda Kappa fraternity, national medical society, "for conspicuous achievement in the medical sciences".

The presentation took place at the fraternity's annual dinner at the Hotel Victoria at the close of the organization's 3-day convention.

Dr. Isidore Kaufman, of the University of Pennsylvania College of Medicine, who made the presentation while those present stood and applauded, hailed Dr. Schick as the man who had done "more than all of medicine put together for the prevention of diphtheria".

In response, Dr. Schick gave part of the credit for his discovery to fortunate circumstances. He likened himself to one of many "who looks out of a great building with many windows and is fortunate enough to see a little something".

"It is a part of our tradition", he said, "to look with respect on our parents and teachers. It is to them that I must return thanks and to the Universities of Graz and Vienna and especially to the children's clinic there. I also want to pay tribute to the Trustees of Mount Sinai Hospital for their help."

The 3 previous recipients of the medal are Dr. Jay Frank Schamberg, Director of the Dermatological Research Institute of Philadelphia; Dr. Solomon Solis-Cohen, Professor Emeritus at the University of Pennsylvania College of Medicine; and Dr. Julius Friedenwald, of the University of Maryland School of Medicine.

The annual gold medal for the best thesis on a medical subject written by an undergraduate went to 2 brothers, students at the University of Buffalo School of Medicine.

NOTICE OF ADOPTION OF MERGER AGREEMENT

Notice is hereby given that a joint agreement of merger and consolidation, dated and executed the 29th day of December, 1932, by and between Homeopathic Hospital of Essex County and the East Orange Dispensary, both being corporations of New Jersey maintaining hospitals or similar institutions supported in part by private charity, in the City of East Orange, Essex County, New Jersey, has been adopted by the respective Trustees and Governors of said corporations.

Said agreement provides for the merger and consolidation of said corporations into a single corporation, the name of which shall be Homeopathic Hospital of Essex County. Said merger and consolidation will become effective on January 14, 1933.

Copies of said joint agreement are open to inspection by all parties in interest at the office of Homeopathic Hospital of Essex County, Central and Munn Avenues, East Orange, New Jersey, and at the office of the East Orange Dispensary, 91 South Munn Avenue, East Orange, New Jersey.

Dated December 29, 1932.

Homeopathic Hospital of Essex County
By William Adelbert Jones, President.

The East Orange Dispensary
By Nettie D. Gore, President.

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Professors Drummond and Hilditch have recently confirmed that for high vitamins A and D potency, Newfoundland Cod-Liver Oil is markedly superior to Norwegian, Scottish and Icelandic Oils.

They have also shown that vitamin A suffers considerable deterioration when stored in white glass bottles.

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Mead's 10 D Cod Liver Oil also enjoys these advantages, plus the additional value of fortification with Mead's Viosterol to a 10 D potency. This ideal agent gives your patients both vitamins A and D without dosage directions to interfere with your personal instructions. For samples write Mead Johnson & Company, Evansville, Ind., U. S. A. Pioneers in Vitamin Research.

ACHIEVEMENTS IN MEDICINE DRAMATIZED IN NEW RADIO SERIES

On January 8, the House of E. R. Squibb and Sons presented the first of a series of half hour radio programs in keeping with the splendid traditions of its founder.

This half hour of entertainment is on the air every Sunday over the Red Network of the National Broadcasting Company chain, at 4.30 p. m. New York time. It features Frank Black and his orchestra, the Revelers, and as the high spot a dramatization of gripping moments from the history of medicine.

These presentations of music and interesting dramatic episodes are designed to appeal to almost every type of radio listener. The anouncements emphasize that only through a sufficient number of properly trained physicians can a community expect to meet its responsibility for the care and prevention of illness and the protection of health. Impressive reasons are also mentioned as to why the use of the family doctor is a good way to keep down the costs of competent, sympathetic and understanding general medical care.

NICHOLAS MURRAY BUTLER ANNUAL REPORT

(New York Times, Dec. 1932)

"Before the university can do much more than it is now doing the elementary and the secondary schools must bestir themselves really to educate the great mass of the population and to leave off their dabbling in the muddy waters of the anti-philosophies and the psuedo-psychologies in which too many of these schools, in this land at least, are just now immersed. The true task of the elementary and the secondary school is not to fuss with experimental psychologies at the cost of childhood's training and future usefulness, but to bring to bear all the resources of historic and well-tested civilization in simple and understandable form, to offer that body of ordered information that guidance and that kindly discipline which will really prepare youth for an independent, a self-controlled and a well-understood life.

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

County	President	Secretary	Reporter
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CAMDEN.....	A. B. Davis, Camden.....	R. S. Gamon, Camden.....	Vincent Del Duca, Camden
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ESSEX.....	W. H. Areson, Upper Montclair	Frank W. Pinneo, Newark....	E. Le Roy Wood, Newark
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MIDDLESEX...	Robert McKiernan, New Brunsw'k	Samuel Berkow, Perth Amboy..	Samuel Berkow, Perth Amboy
MONMOUTH...	R. E. Watkins, Belmar.....	D. F. Featherston, Asbury Park	R. A. MacKenzie, Asbury Park
MORRIS.....	F. H. Pinckney, Morristown....	Albert J. Ward, Morristown....	Marcus A. Curry, Greystone P'k.
OCEAN.....	Abraham Goldstein, Lakewood..	Alfred Woodhouse, Toms River.	Eugene E. Herbener, Lakewood
PASSAIC.....	Joseph Bergin, Paterson.....	Wayne W. Hall, Paterson.....	Wayne W. Hall, Paterson
SALEM.....	William T. Hilliard, Salem.....	David W. Green, Salem.....	William H. James, Pennsville
SOMERSET.....	Thomas Flynn Somerville.....	A. F. W. Sferra, Bound Brook	J. L. Young, Somerville
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The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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FOCAL INFECTION

Edward Rist remarks in his interesting essay, 'Qu'est-ce que la médicine? that "in every country, our confrères have their phantoms and their ghosts. For the Englishman it is uric acid, for the German the exudative diathesis, for the American focal infection". Although we admit that focal infection has at times been almost done to death by its friends, yet it remains a very solid contribution to medicine. As a distinctively American contribution, it is of interest to note that one of the great pioneer American physicians, Benjamin Rush, was one of the first physicians to recognize the relationship between apical infections and arthritis. Benjamin Rush was born near Philadelphia in 1745 on a homestead founded by his grandfather, a Quaker gunsmith, who had come to America with William Penn. * * * Rush Medical College was named in his honor, although Rush himself received this honor posthumously, since he died nearly 20 years before Cook County was incorporated, with Chicago, a tiny village, as its county seat.—Major, R. H.: Classic Descriptions of Disease, Springfield, Ill., Charles C. Thomas, 1932, page 178.

POINTS TO OUTSIDE LECTURES

"Another phase of the part that the medical school plays in the community, both medical and lay, which is not usually appreciated," the dean said, "is that of informal education through lectures, addresses and radio talks to groups outside of the university. Last year members of our faculty gave over 200 such addresses.

"In addition to this, the constant activities of the faculty as members of important committees and officers of scientific, public health and civic organizations are in important contribution to the school, to the community and nation."

The dean reported that 479 students, including twenty-six women, were registered for the degree of Doctor of Medicine during the season 1931-32. In the graduating class were 113 students, of whom 102 received appointments to forty-five hospitals. Changes in the faculty included the appointment of fifty-eight new teachers, the promotion of eighteen and the retirement of thirty others. The medical treatises published by members of the faculty during the year amounted to 143 items.

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McKesson's Vitamin Concentrate of Cod-Liver Oil is supplied in the strength of 11-A and 11-D, suspended in a neutral oil to preserve the vitamins against oxidation. It is flavored slightly to render it more palatable, and in its administration minims from a specially designed dropper are substituted for teaspoonfuls.

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INSURANCE FOR HOSPITALIZATION

(Editorial from N. Y. Medical Week, Nov. 26, 1932)

Physicians and hospitals alike will be interested in the outcome of the study which has been undertaken by the New York Hospital Conference and the Hospital Information and Service Bureau of the United Hospital Fund to determine the feasibility of various plans which have been suggested for the group purchase of institutional care. Many doctors have failed to receive payment for their services because hospital bills have exhausted the patient's financial resources. The hospitals themselves are not exempt from imposition. Because of the failure of people generally to make provision for illness during health, many an institution is required to carry patients in its free wards who should be paying at least the semi-private rate.

The contributory schemes which have worked out so well in Great Britain could not be transferred to America without striking changes. The class of people who have subscribed so enthusiastically to this system in England is the class which previously had gone to the rather undesirable Poor Law institutions. In America this same economic stratum is treated competently and without the stigma of pauperism in both municipal and voluntary hospitals. Our need is for a plan which would take care of the institutional requirements of middle-class patients who would normally apply for semi-private and low priced private accommodations.

The provision of hospital facilities for this class of people under a group purchase plan is rendered the more complex by the fact that these patients desire to select their own physicians; in most of the voluntary institutions in Great Britain, which have ward accommodations chiefly, practically all patients are under the free care of the hospital staff and have no word in the choice of their attendants. In view of the fact that almost all of the better hospitals here are so-called closed institutions and that any one physician has limited hospital privileges, any insurance scheme for Greater New York would have to embrace all or most of the city's hospitals and all participating institutions would have to be open to all of the medical men connected with the plan.

Obviously there are many difficulties involved in the establishment of a system of hospital insurance which will allow the free choice of physicians and permits of a practical method of distributing patients among the various institutions of the city. None of the obstacles which present themselves are insurmountable, however, and their conquest will benefit hospitals, doctors and patients alike.

Many institutions have already had occasion to consider insurance projects that have been submitted to them. If each hospital attempts to sell a group purchase scheme separately, the result can only be chaos. It is essential to the success of any plan that a sufficiently large number of institutions participate to permit of the accommodation and proper distribution of subscribers even during epidemics and seasons when the peak of hospitalization is reached.

The survey which is now under way promises to be completed in a relatively short time. The ex-

Continued on page XXV.


APPROACH

DR. BARNES SANITARIUM

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Completely equipped for scientific treatment and special attention needed in each case. Diversional aids provided, including a fully equipped occupational therapy department.

Booklet upon request.

F. H. BARNES, M.D.,
Med. Supt.

Continued from page XXIV

perience and responsibility of the organizations which are directing it vouchsafe the dependability of the forthcoming reports. It would be well if hospitals which are considering independent insurance plans would withhold decision until the investigation which is now in progress has been completed.

No one is more vitally concerned in the creation of a practical system for the group purchase of hospital service than the medical profession. Its advice and coöperation are essential to the success of any such plan. The Medical Society of the County of New York has an Advisory Committee of hospital directors and superintendents for the study of problems of this type. It would be a step in the right direction if the results of the investigation which is now under way were submitted to this Committee for joint consideration by the hospitals and organized medicine.

We Care Nacht a Jacht

A lady named Schacht sailed away on a yacht.
Her foot gacht cacht in a sailor's knacht
And pitched her into a lobster pacht.
She facht and wracht till she was hacht,
She swore a lacht and said she'd nacht
Go sailing again in that lobster's yacht.
—Cincinnati Enquirer.

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Offers a practical, palatable combination of the two most desirable carbohydrate foods for this purpose.

Lacto-Dextrin is not a drug—it is a food—easy to take.

For sample and literature write Dept . . . .
THE BATTLE CREEK FOOD COMPANY
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FINDS ADVERTISING AIDS IN THE WAR ON DISEASE

The Julius Rosenwald Fund published the results of a survey of newspaper medical advertising in the last 10 years, conducted by Miss Mary Ross, of New York, and covering all efforts made in the way of public education in health problems by medical organizations, non-profiting institutes and private businesses.

No conclusions are offered and no recommendations, but the results of campaigns in different fields are presented. Michael M. Davis, Director for medical services of the fund, in a commentary chapter, however, concludes tentatively:

That there is a widespread demand for information by the public.

That newspaper advertising is only one channel of publicity, in addition to speakers, pamphlets, radio talks and press bureaus.

That newspapers are coöperating well in the effort to keep out quack advertising and that all campaigns should be under the control of professional men, both medical and advertising experts.

That advertising yields definite results, but only in the proportion that its aims are against a specific disease rather than general.

That campaigns must be continued over long periods, since the effect is cumulative.

That closer relations between editors and doctors would be of mutual advantages.

The report points out that personal advertising by physicians is unethical, but that educational advertising by medical groups to help the public to understand disease is approved and is often effective if well handled.

THE OLD-FASHIONED DOCTOR

(New York Times)

In his annual report to President Butler, Dean Rappleye of Columbia School of Medicine addresses himself to medical economics—a question recently considered by the Committee on Medical Costs. He warns against adopting any program that endeavors to reduce professional services to "mere terms of economics and organization". Physicians have always insisted that the practice of medicine is not only a science but an art. It follows that the "art" must suffer if a patient is treated as if he were merely a living machine.

Medical art finds expression in the personal relationship between physician and patient as well as in skill and knowledge. Hence the pleas recently heard on behalf of the old-fashioned family physician. He knew the whims of Aunt Sarah and the aches of Uncle Joe. What he lacked in special knowledge he more than made up by his personality and the confidence that he inspired. He embodied "the attributes of friend, priest and physician", as Dr. Squier aptly put it in his recent presidential address before the American College of Surgeons. Contrast human sympathy in sickness with the mechanical routine inseparable from rigid organization and economics, and we grasp the implications of that "art" which we are in danger of losing.

Both the majority and minority reports of the Committee on Medical Costs advocate restoring the general practitioner to his old position. If the ratio of physicians to population were in the United States what it is in France or Germany, we should have some 75,000, Dean Rappleye tells us. Actually we have about 156,000, concentrated for the most part in cities. Solve the problem of finding practice for this over-supply, and we not only solve the problem of medical costs, without resorting to the kind of organization that Dean Rappleye fears, but also enable the old-fashioned family doctor to demonstrate what the Hippocratic oath really means.

CONFIRM TRACHOMA GERM

Three physicians of the Rockefeller Institute publish a report of their studies in the current issue of Science which gives proof of the validity of the discovery by the late Dr. Hideyo Noguchi, their colleague, of Bacterium granulosis, the germ he held caused trachoma, an eye disease, Science Service reported recently. The report said that the research workers, Drs. Peter K. Olitsky, Jerome T. Syverton and Joseph R. Tyler, believed that their studies had fulfilled conditions demanded by Dr. Ida A. Bengtson, who challenged the discovery.

Dr. Bengtson, senior bacteriologist of the United States Institute of Health, in a review of trachoma research, had said that if certain conditions were complied with she would come closer to being convinced that the germ caused human trachoma. The experiments, it was reported, produced in monkeys typical and identical cases of trachoma both from Noguchi's bacterium and from infected tissues from human cases of the disease. The experiments, the doctors held, proved that the germ caused the disease.

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Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906. at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 3 Orange, N. J., March, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

THE N.Y. ACAD. OF MEDICINE
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YEAR'S REPORT MADE BY HOSPITAL UNITS

(Newark Evening News, Feb. 1)

The Hospital of St. Barnabas and for Women and Children treated 14,278 patients last year, including 4903 admissions to bed service and 9375 patients treated in clinics, it was announced in the annual reports of the Superintendents, Rev. John G. Martin and Miss Alma M. Viehdorfer. Although the general rate of bed occupancy in hospitals throughout the country averages below 60%, the rate at the St. Barnabas unit reached 75%, Mr. Martin stated.

The cost of free and part free service last year amounted to $96,729.54 and the total expenses of the 2 units were $296,983.18. The total receipts amounted to $271,721.16, including the hospital receipts, Community Chest appropriation, $2500 from the City of Newark, and donations; leaving a deficit of $25,262.02. The budget for the coming year anticipates an expenditure of $250,000, a reduction of $33,929 below that of last year, and every effort will be made to keep within the estimate, it was reported.

While it is impractible at this time to seek funds for the new building needed by St. Barnabas's for some years, redecoration of rooms and wards has been authorized, Mr. Martin announced.

There were 747 infants born at the 2 units last year, with male children slightly in the majority.

The Superintendents commended the Hospital Council of Essex County as having effected savings through group purchasing and declared it had been helpful in the collection of delinquent accounts and in holding conferences to bring about better hospital methods and coördination. Mr. Martin declared the coöperation between the St. Barnabas unit and the Women's and Children's unit has been noteworthy in the last year and expressed hope of further progress.

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VIVISECTIONISTS WARNED

(New York Times, March 5)

Antivivisectionists' activities are endangering the advance of science, President Livington Farrand of Cornell University declares in a letter to the Medical Society of the State of New York.

Two bills now before the Legislature would prohibit experimentation on living dogs and would provide penalties.

Dr. Farrand's letter said that "any one familiar with the history of modern medicine must recognize that these discoveries which have freed the world from so much sickness, misery and despair have followed almost without exception upon tests and experiments upon lower animals. Of all the animals available for such experimentation one of the most important is the dog. It is true that the dog is more closely tied with man's affections than any other animal, but the proper use of the dog for experimentations must continue if progress is to be made, and the present methods of our laboratories insure humane treatment of this friend of man."



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I'm going to bring him down to your office Wednesday as you suggested. That S.M.A. folder you gave me says even a breast fed baby should be under the supervision of a physician and I think myself that it's better to *keep* the baby well than to wait until trouble starts.

We certainly want to thank you for bringing our baby along so well, Doctor. It increases our confidence in you as our family physician. Tom has already "said it with dollars" but I wanted to thank you personally, too.

And I'm going to persuade Mrs. Brown,—that's my neighbor with the baby that's not gaining—to come along on Wednesday so you can prescribe the proper diet for *him* too.

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Your family may not have a regular physician. Perhaps it's because you live in a large city, perhaps it's because you've moved recently and so are out of touch with your former doctor. Whatever the reason, if you do not now have a family doctor, get one. Do it now—do not let the health you enjoy today make you careless in providing this vital safeguard against the sickness tomorrow may bring. Find and become acquainted with the person to whom you can entrust the medical welfare of your family through the years to come.

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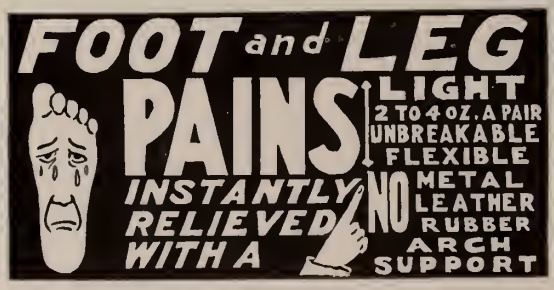
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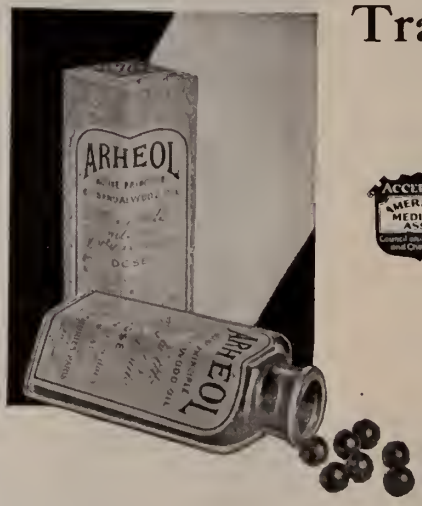
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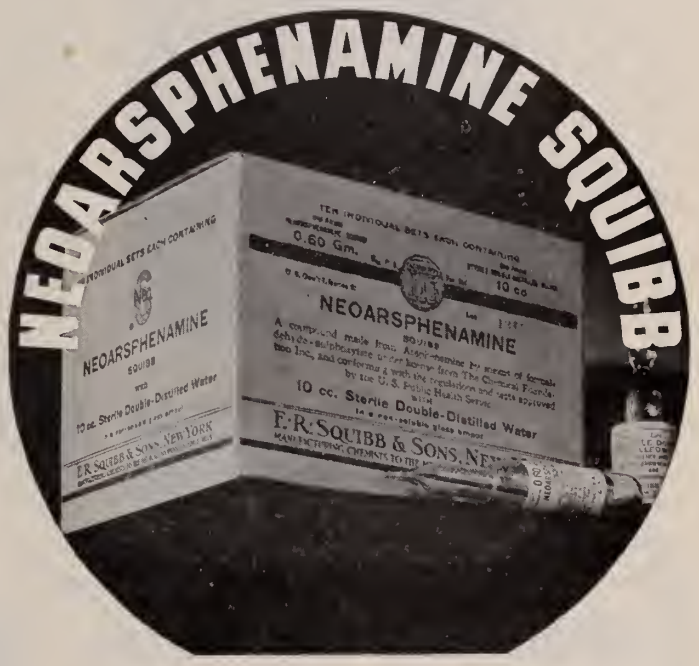
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Vol. XXX., No. 3 ORANGE, N. J., MARCH, 1933 Subscription, $3.00 per Year
Single Copies, 30 Cents

TUBERCULOSIS IN SCHOOL CHILDREN

B. S. Pollak, M.D., F.A.C.P.,

Medical Director, Hudson County Tuberculosis Hospital and Sanatorium; Chief, Tuberculosis Division of the Jersey City Medical Center; Chief, Tuberculosis Division of Christ Hospital, Jersey City; Consultant Phthisiologist, Margaret Hague Maternity Hospital, Jersey City, Bayonne Hospital, St. Mary's Hospital, Hoboken, Beth Israel Hospital, Newark; Chairman, Medical Board of Deborah Tuberculosis Sanatorium;

and

B. P. Potter, M.D.,

Resident Physician, Hudson County Tuberculosis Hospital and Sanatorium

For the past 10 years or so, the diagnosis of tuberculosis in childhood has attracted considerable attention, but the question was recently crystallized by the contributions of Chadwick, McPhedran and others, for the conclusions reached by these investigators emphasized the fact, made obvious by the teachings of Ghon, Von Pirquet, Ranke and others, that tuberculosis in childhood differs largely from tuberculosis of the adult type. As a result of these investigations, an intensive study of the problem was stimulated and some more or less definite conclusions were arrived at; culminating in a brochure entitled—"Childhood Type of Tuberculosis"—published by the National Tuberculosis Association.

The type of tuberculosis in children which can be diagnosed by the ordinary academic method does not for the moment enter into this discussion. It is the group of children with tuberculous disease unaccompanied by the usual clinical manifestations or physical signs that presents the greatest difficulties to the medical examiner. These latent infections are generally recognized by the tuberculin test and x-ray examination. A history of contact with tuberculosis is, obviously, also important, though difficult to obtain from school children.

Tuberculosis in childhood is an outstanding problem connected with our present tuberculosis propaganda, and depending upon our concept of this problem rests the solution and gradual control of tuberculosis; and the solution of this problem depends largely upon a clear understanding of the pathogenesis and pathology of tuberculosis in childhood. In other words, we must clearly understand the systemic reaction to the tubercle bacillus in order to properly comprehend its *modus vivendi*.

The immediate response of pulmonary tissue to a primary tubercle bacillus infection is a nodular or diffuse lesion; which may occur in any part of the lung as a formation in the parenchyma, usually adjacent to the pleura, with a central caseation. In unfavorable cases, particularly in infants, peripheral spread takes place, from the focus to an invasion of the lung. In favorable cases, which are not rare in infancy and constitute the majority of lesions in older children, the caseated area remains small, say 0.2 to 0.6 c.c., and the tuberculous tissue about it becomes reduced to a fibrous capsule. A deposit of calcium usually occurs in the caseous nodule. We desire to emphasize this point because of its importance in our study of the roentgenogram. A similar sequence of events takes place almost simultaneously in the tracheobronchial lymph glands which drain the diseased area. It not infre-

quently happens that the primary lesion in the lung is so small that it escapes notice, and the roentgenologic evidence varies according to the phase of the disease at the time the picture is taken. A roentgenogram may, therefore, show: a small fresh focus or a diffuse infiltration in the lung with or without demonstrable uncalcified nodes; a primary nodule in a lung with or without calcified glands massed in the hilum; or, calcified masses in the hilum and no obvious disease in the lung, only circumscribed masses of caseous gland projecting from the hilum out into the parenchyma of the lung.

There are occasional cases in which the infiltrated process is not absorbed and excavation of the caseous center takes place. This form of lesion may then spread throughout the lung and result in generalized tuberculosis or it may retrogress to healing. Regardless of the age at which it develops, the childhood type is that form of lung tuberculosis which results from a first infection and which is characterized by the pathologic lesions above enumerated. The essential difference between the childhood and the adult types may be listed, according to Chadwick, as follows:

Childhood type. (1) Common in children, rare in adults. (2) Results from first infection. (3) Associated tracheobronchial lymph nodes always involved but not always demonstrable. (4) Lesion involves any part of lung; no preferred sites. (5) Caseous lesions usually followed by calcification and slight fibrosis. (6) Infiltrated areas commonly resolve, leaving little or no scar except for focal caseation which usually becomes calcified. (7) In general, a greater tendency to rapid spread of lesions and to development of miliary tuberculosis. (8) Cavities not apical; not close to pleura; form quickly and are more easily healed. (9) Prognosis is good.

Adult type. (1) Common in adults, rare in children. (2) Results from re-infection. (3) Tracheobronchial lymph nodes not involved. (4) Apical localization; often in lung opposite to that containing calcified primary focus and calcified tracheobronchial glands. (5) Caseous lesions usually followed by excavation and much fibrosis. (6) Infiltrated areas heal with much fibrosis. (7) In general, a greater tendency to encapsulation and to healing of lesions. (8) Cavities apical; close to and adherent to pleura; relatively rigid; and do not heal easily. (9) When this type affects a child, the prognosis is bad.

Early diagnosis of tuberculosis in children leads the way toward prevention and cure of that disease. The importance of discovering the early lesion is obvious, for knowledge of its existence may enable the physician to prevent the catastrophe of a later developing adult type of pulmonary tuberculosis. The patient's history should be gone into thoroughly, to determine whether any member of the family has had tuberculosis and, if so, whether there has been any actual contact; also, whether there has been contact with a tuberculous servant or other person. If the patient has a chronic cough, the record of a past illness, such as whooping cough or measles complicated by bronchopneumonia, may throw some light on the subject.

Although there are no characteristic symptoms, the following should attract attention: undernourishment; failure to grow and gain weight, or an actual loss in weight; poor appetite; fatigue; lack of energy; a tendency to nervousness or irritability; poor resistance to minor ailments; frequent colds; cough, usually non-productive. Fever is usually present but of the mild degree which is so commonly caused by other conditions in childhood.

The above symptoms may be caused by a number of other conditions, such as diseased tonsils and adenoids, sinusitis, uncinariasis, pyelitis or cardiac disease. On the other hand, many children have the childhood type of tuberculosis without manifesting any symptoms that can be ascribed to that disease, although they may have a progressive lesion.

Physical examination of the chest reveals no characteristic signs in the childhood type of tuberculosis. In order to produce signs, the mass of lymph nodes must be large enough to form a considerable mediastinal tumor, or be so situated as to produce pressure upon the trachea or bronchi; though the latter condition is rare.

The primary focus is so small and so lack-

ing in collateral inflammation, and the enlarged tracheobronchial glands are so deep-seated that impaired percussion note, altered breath sounds and râles, are lacking. D'Espine's sign, paravertebral dulness and scattered râles are as common in children who give a negative tuberculin test as in those having any but very advanced tracheobronchial tuberculosis. Such physical signs as anemic mucous membranes, pale skin, poorly developed and flabby muscles, are more common than in the non-tuberculous child though at times those with the childhood type of tuberculosis may appear perfectly nourished and healthy.

The physical and laboratory examinations in the study of childhood tuberculosis are of more value in the discovery of other abnormal conditions which might explain the symptoms than in demonstrating the presence of a tuberculous lesion. The discovery of diseased tonsils, otitis media, heart disease, pyuria, intestinal parasites or ova, or of malarial parasites, should indicate the need of caution before diagnosing the condition as tuberculosis. If there are no defects, or if the suspicious symptoms persist after such defects are corrected, it is much more likely that the case condition is one of tracheobronchial tuberculosis. Tubercle bacilli are very rarely found. In 4 patients only, during the past 2 years in our clinic, did we find tubercle bacilli, and all had tuberculosis of the adult type.

The absence of definite symptoms, physical signs and laboratory findings, makes the roentgenogram of greater diagnostic value in the childhood than in the adult type of pulmonary tuberculosis; in fact, it is only by this means that tracheobronchial tuberculosis can be definitely demonstrated. Hence, suspicious symptoms, with no other discoverable cause, and a well-marked tuberculin reaction, justify a tentative or strongly probable diagnosis of the childhood type of tuberculosis even though roentgenographic examination proves negative. A history of prolonged exposure to open tuberculosis makes the diagnosis more certain. Roentgenographic evidence of tracheobronchial lesions is not sufficient for a diagnosis of active tuberculosis, without a positive tuberculin test and suspicious symptoms. We have found the tuberculin test valuable in the diagnosis of clinical tuberculosis and think it should be routinely employed upon all suspected persons.

In a well-organized clinic or hospital, the intracutaneous or Mantoux test, is the method of choice, owing to the fact that it is more sensitive and has a quantitative value. We use dilutions of 1:1000 *old tuberculin* in 0.1 c.c. amounts (0.1 mgm.). If the weaker dilution is negative and the condition is suspicious, we repeat the test with 0.1 c.c. of 1:1000 dilution (1.0 mgm.), taking care to use the other arm, because a first test will increase the sensitivity of that area, and a second test on the same arm is apt to give a false impression. The tests are read in 48 hours and again in 7 days.

A *positive* tuberculin reaction means that tubercle bacilli have lived and grown in the body; but the child may or may not have demonstrable tuberculosis. A *negative* test gives valuable information and means that the child had no tuberculous infection, with few exceptions. For the period of a few weeks following measles, whooping cough, influenza, and perhaps some other acute diseases, there is supposed to be a suppression of tissue allergy, and the test should be repeated before tuberculous infection can be ruled out. Also, in advanced tuberculosis the resistance is so overwhelmed that the test may result negatively.

In regard to the Mantoux test, we desire at this time to quote our statistics in a series of 7362 tests made during the period between February 1, 1930, and February 1, 1932, in the Hudson County Tuberculosis Clinics. The clinics cover the county, which is largely industrial and has a high percentage of foreign-born residents. The economic status of most of those coming to the clinics is not high, a fact which must be taken into consideration when interpreting the results of the tests. The group of persons tested ranged in age from birth to 21 years, with 80% between 6 and 15 years. For the first few months the Von Pirquet test was also used, but when it was found that the Mantoux and Pirquet tests give identical results, this procedure was discontinued. All persons reacting positively were

then x-rayed, but the examination results have not yet been tabulated.

Of all those tested, 56% reacted positively.

This is less than Drolet found, using the Pirquet test in 1912 to 1916, where 64% of those tested gave positive reactions. Veeden and Johnson, in the St. Louis clinic, found that 32% of all children and 21% of the well children gave positive reactions, while Bartschmid, in Munich, and Pirquet, in Vienna, reported 43% and 38% positives, respectively. All of these studies were based on groups of children somewhat younger than those tested in the Hudson County Clinics, none of which included persons over 15 years of age. Hetherington, Opie and McPhedran, whose study included persons up to 20 years of age, found 74% of positive reactors although they worked with a normal school population which would be expected to show fewer positive reactors than a clinic group. Thinius, working with school children of Stolp i Polm from 6 to 18 years of age, found 61% positive; while Overland, in Bergen, found 39% of his school group positive.

The analysis of the Hudson County group by ages shows the usual increase in positive reactors in the older-age groups. The high percentage in the age group of 16 to 21 years is slightly less than the 83% found among the Philadelphia school children of ages 14 to 19.

Of the children given the Mantoux test, 54% had a history of exposure to tuberculosis. Only 39% of those not exposed gave positive reactions, while 71% of those exposed reacted positively. This relationship holds for each age group, although as age increases the difference in positive reactions in the 2 groups is not so great. For the age group under 6 years, 21% of those not exposed were positive, while more than 2½ times as many, or 55.6%, of those exposed were positive. For the age group 6 to 10 years, those exposed showed only 1.9 as many positive as those not exposed; for the age group 11 to 15, the exposed group were only 1.6 times as frequently positive, and for the 16 to 21 year old group, the positive exposed were positive only 1.3 times as frequently as the non-exposed.

The 7326 children were classified by the physicians of our service according to clearly defined standards as in—Good—Fair—or Poor—health, and it was found that those in *poor* health had the lowest percentage of positive reactors in every age group. In general, those in *fair* health had a slightly higher percentage of reactors than those in *good* health; which was also true in each age group except that of 6 to 10 years, where the children in *good* health showed 52% of positives while those in *fair* health showed 50% positive reactors. These findings tend to confirm those of Hetherington, who studied 1999 school children aged 5 to 16 inclusive, and found that normal and over-weight children gave positive reactions in 72.6%, while under-weight children gave 71.5% of positive reactions. Hetherington says "there is no evidence that latent tuberculosis is a factor in the production of malnutrition", and warns against the danger of depending on this as a symptom of tracheobronchial tuberculosis.

The dangers from exposure are clearly shown by analysis of the children on the basis of general health and history of exposure. The percentage of exposed was nearly the same in each group, with 70% of those in *good,* 74% *fair,* and 71% *poor* health. The percentage of the non-exposed varied from 28% of those in poor health to 45% of those in fair health. This would suggest that history or exposure is a much better indication of infection than is poor health.

From our studies of conditions in New Jersey, and particularly in Hudson County, and an extensive review of the literature, we are prompted to believe that the eventual control of adult phthisis will depend largely upon efforts made for the control of childhood tuberculosis and tuberculous infection in childhood. Overwhelming evidence points to the fact that while most tuberculosis is due to familial contact, the public school is contributing its share. This could and should be avoided. Tuberculous teachers and employees connected with the school system must be eliminated. Only too frequently has it come to our attention that tuberculous infection of children has been traceable to such sources. While it may be

too radical to say that all children entering the public schools must be subjected to the tuberculin test, it is a problem requiring serious consideration. We agree entirely with Meyers, of Minnesota, who says the following are some of the reasons why childhood is the best age period to study and teach concerning tuberculosis: (1) The child's mind is impressionable and retentive. (2) Children are gathered in large groups. (3) Consent for examination is more easily obtainable than in later life. (4) Tuberculosis of a community is reflected in the children of that community.

In searching for tuberculosis among school children, the ideal procedure would be to examine all children but owing to numbers this would be difficult at the start. As a minimum, all contact children, and all children suspected of having tuberculosis, should have the tuberculin test, and all who react should have the Roentgen-ray examination. Children who have been exposed to infection should be kept under medical supervision, even though a solitary tuberculin test and the roentgenogram be negative. No examination or test should be made until a parent or guardian has given *written consent*.

The school physician can aid materially in solving the problem. The school may not entirely lend itself to the carrying out of all details involved but the school physician, in cooperation with the family physician, who, after all, is the important factor in disease control, will help the tuberculosis agencies, hospitals, clinics and sanatoriums in bringing to attention all children with open and active tuberculosis, whose segregation will eventually substantially diminish tuberculosis among school children.

DISCUSSION

Dr. Abraham E. Jaffin (Jersey City): I do not know whether it was in order for me to discuss this paper, but I came here because I thought this was a very timely thing to bring out. It is a great pity that we haven't a much larger attendance of school physicians, because it is primarily only through the school physicians that we will ever be able to get somewhere on the path toward that millennium of which Dr. Pollak and others in this work are dreaming, where we can spot the future tuberculous adults. That, I believe, is in the *teen* age.

I am not so much worried, and I am sure that Dr. Pollak is not, about school children under the *teen* ages. They, with their primary lesions, as a rule, with modern standards of living and the habits of childhood, contend with their problem in a fairly satisfactory manner. I do not mean to imply that we should ignore that age. There are, of course, problems there too. But, we are all aware of the much more serious problem that involves the child past the puberty age, with the added drains on vitality incident to domestic, social and economic factors which lay the basis for the important adult type, or re-infection.

If we can some day clearly test these children in the teen age with tuberculin and select the reactors, and have radiographs of their chests, I know, from my own experience covering a period of more years than I am willing to admit here, that we will find those who give us our hopeless adult forms of tuberculosis.

I do not know why this cannot be done, either in the schools or by the family physicians. That, of course, is an economic problem which is now facing us, and which is difficult to solve, but it is no great operation to make such a test and if it cannot be done in the schools, where I think it would be ideal to carry it out, at least the nucleus for it, or the stimulus for it, could emanate from the schools until the profession at large adopts it. I think it would be for their own good that the problem was begun in the schools and when family physicians are prepared to take it over the schools, I am sure, would be very glad to discard it and do without it.

The deduction of tuberculous infection is surely just as important as immunization against diphtheria, yet we have now reached the point where using toxin-antitoxin is practically universal.

I would like to say one word in clarification of the term "childhood tuberculosis". For a number of years it was one of confusion in my own mind, but after some study and conferences with pathologists who had seen a lot of it, particularly abroad, I feel that some of the confusion that has arisen from the pamphlet put out by the National Tuberculosis Association may be cleared up rather easily.

I may perhaps use the blackboard to advantage. Dr. Pollak has already indicated that all tuberculous infection is not disease. The confusion arises, however, in the definition of childhood type of tuberculosis as being one where there is a primary infection which may be discrete, localized or diffused. As a matter of fact, those we will see in schools or clinics are usually the primary localized types of infection. There is, however, a diffuse type which is very rare. That type, when encountered, is not recognizable at first as a tuberculous infection but presents itself to us more as a picture of bronchial pneumonia, complicating a preceding upper respiratory infection. It may have followed whooping cough, or measles, and we find a bronchial pneumonia. It is only by its persistence, its long-drawn-out course, and its rapidly downward course in a young infant, that we begin to be suspicious. (Using a blackboard, Dr. Jaffin demonstrated some differences between the childhood and adult types of tuberculosis.)

Dr. Marcus W. Newcomb (Brown's Mills): I am sorry that we had not a larger audience to hear this paper, which, perhaps should have been delivered at a general session, for that is where we need to get these papers, before the general men. The question of tuberculosis in school children is an important one because, if we are ever going to control tuberculosis, we have to begin with the children.

We think we have accomplished a lot, and we have; but perhaps we have just scratched the sur-

face in tuberculosis work, because, after all, between certain ages more people die with tuberculosis than with any other disease.

Dr. Pollak covered it very thoroughly all the way down. A very important part is the taking of the history. The parents may not have tuberculosis, and the grand-parents may have had it but were never in contact with the child; but perhaps a servant in the home may have had a *winter* cough, or a *stomach* cough, or a *nervous* cough.

You cannot make a diagnosis of childhood tuberculosis on physical examinations only. You must make the Mantoux test, and x-rays and the history, and you must use all of them to make a diagnosis.

In our clinic we never ask parents about giving the Mantoux test. When they bring their child to the clinic, we take it for granted that they are bringing it there to find out what is the matter with it. If they do not want to let us do what we want to do to find out, then let them take the child home and guess at it themselves. We do not stand on ceremony so far as that is concerned.

In the schools, that is different. Your work in the Normal Schools is a very good thing, but I think you want to get your patients before they get to the Normal Schools. By that time you are going to have a lot of cases that have passed from the stage of childhood tuberculosis into an active tuberculosis.

Some of you may think that you haven't any children in your schools with active tuberculosis, but I say you have. You have plenty of them if you will only look for them. You have plenty of them in your *grades*, and you have plenty of them in your *high* schools. You probably have some on your athletic teams with active tuberculosis right this minute, and you do not know it.

You should not let a boy or a girl play basket-ball or foot-ball or base-ball when he or she has active tuberculosis. If you do, you know what you are going to have later.

I have a number of patients in the sanatorium now, of high school age, with positive sputum. I have one in there, 10 years old. When he came in he was about 7 years old, with a positive sputum, an adult type.

What is true in South Jersey is true in North Jersey. It isn't just simply peculiar to South Jersey. You also have teachers in your schools, as Dr. Pollak said, with active tuberculosis. Only within the past month I have admitted 2 school teachers with far advanced pulmonary tuberculosis, and positive sputum. One of them was teaching in the primary grade up until 2 weeks before she came to me. She has a cavity in the apex with 1 chance in 10,000,000 of ever getting any better.

That is the condition we have in the State of New Jersey, and they have it in other states.

Only 2 years ago I admitted a high school boy who had been playing foot-ball from September until the middle of December, and he had a hemorrhage on the field. He had played foot-ball the whole season. He had an active case of tuberculosis. He passed on, many months ago.

Our problem is with the school child. We ought to have every child examined, and every child that has been in contact should have a tuberculin test, at least, and for every one that gives a positive reaction we should have stereoscopic pictures. That is the only way I know to get at it. The teachers, or the janitors, or anyone else connected with school children, should also have an examination and be required to give a clean bill of health.

I hope next year to introduce a bill that will require teachers to have an examination, with stereoscopic pictures, before they can sign a contract. It may not get any farther than it did this year, but if I live it is going in on the first day of the session in 1933 just the same.

Dr. B. P. Potter (Hudson County Tuberculosis Hospital): It was shown recently in the Metropolitan Hospital, New York, that—to the average percentage of positive sputums found in children, another 15% can be added by analyzing the stomach washings. The value of this procedure, however, is debatable, for experience with this procedure at the Harriet Lane Section of Johns Hopkins Hospital has been discouraging. In addition, the foreign literature indicates that the small number of positive sputums found by this procedure do not warrant its routine application. It should also be remembered that this test is difficult and often troublesome to the doctor as well as to the youngster.

Another point I wish to stress is the fact that, even at present, many physicians ask the mother or whoever happens to bring the child—whether the child has been thin all along. There is ample evidence that it does not make any difference whether the child is husky and looks well or is thin and emaciated. Either one may have either latent or active childhood tuberculosis.

I wish to take this opportunity to thank Dr. Pollak for having given me credit for the negligible part that I had in this paper.

Dr. Grace M. Kahrs (Newark): To return to Dr. Newcomb's discussion, I would like to add one illustrative case to emphasize what he said about the presence of tuberculous students in our schools. Recently, in visiting Dr. Pollak's institution with a group of teachers, I was confronted by one of them, at the end of our trip, who told me she had found 3 of her Junior High School students in the ward designated to those most seriously ill.

She said: "Think of it, they were all Grade E students and we teachers were combining even this year, to force them up in their grades."

Following that experience 3 other teachers came and said they had found 1 girl apiece from their classes, under treatment there.

DIAGNOSIS OF PULMONARY TUBERCULOSIS IN INFANCY AND CHILDHOOD

Murray H. Bass, M.D.,
Associate Pediatrist, Mount Sinai Hospital
New York City

During the past 2 decades we have been fortunate in adding to our knowledge of tuberculosis many facts of great value; an advance made possible by the development of new methods of diagnosis. Simplification of the tuberculin test, by Pirquet, stimulated pediatrists all over the world to study the incidence of that disease so that our knowledge of its occurrence is no longer dependent on

purely clinical, physical examinations and study of autopsy material. A simple, harmless method of diagnosis had been given the physician, out of which the whole conception of tuberculous infection was to be changed. Modifications of the cutaneous test soon appeared and by its use we became able to pick out cases of tuberculous infection which failed to react to the less delicate Pirquet test.

Along with this development came improvement in x-ray technic. Better machines, better tubes, better methods, made the study of pulmonary tuberculosis a really exact science. Not only were physicians able to follow the progress of their patients more carefully, but they were able to record it graphically so that it might be observed and interpreted by others. At the present time every physician who considers himself thoroughly educated in clinical matters must be able to read a radiograph of the chest. In the study of patients not only are series of x-ray films of great importance, but use of the fluoroscope has become almost a routine procedure.

With these 2 major diagnostic aids, the tuberculin test and the Roentgen rays, a pathway has been blazed through what was once an impenetrable forest, and the clinician of today stands upon much firmer ground, when making a diagnosis of tuberculosis, than ever before. The cutaneous tuberculin test was discovered and perfected by a pediatrician, and as it was soon found that infants and children were easily infected by the tubercle bacillus, even when not showing clinical evidence of disease, infection during childhood became a much studied question. Later on, it was found that the infant and child have a tendency to develop a *particular type* of tuberculosis, and that upon this type or form depended the kind of infection he might show in adult life. Moreover, we have learned that the outcome, for tuberculous patient, depends, among other factors, upon the age at which infection takes place; and that infection in the very young is fraught with much greater danger than if acquired later in childhood. In other words, infancy and childhood became an important period for the study of infection of the human being and, in consequence, it fell to the lot of pediatricians to be in the front ranks of those trying to advance knowledge of the natural history of tuberculosis.

Naturally, in the course of 2 decades a colossal amount of material has been assembled, and it is obviously impossible to more than sketch a brief review of recent advances. Although we are all in general agreement as to the main facts concerning tuberculous infection in childhood, we differ as to exact diagnostic methods. It seemed to me, therefore, worth-while to stop, look about, and see where we stand as to ability to recognize the presence of tuberculosis during infancy and childhood.

What diagnostic means are at our disposal for determining whether or not a child has been infected with the tubercle bacillus? They are as follows: (1) The history. (2) Physical examination. (3) Bacteriologic evidence. (4) X-ray evidence. (5) Tuberculin tests.

One need scarcely do more than mention the importance of obtaining a history of exposure, for medical literature now abounds in statistics showing that, especially in the earlier years of life, even brief exposure to open tuberculosis suffices to infect the lungs of a child. Careful questioning as to exposure is, therefore, of the utmost importance. Physical examination of the lungs is often extremely disappointing. It is a common experience to find by x-ray examination large areas of intrathoracic involvement, with almost no physical signs. Stewart points out that if we assign to the tuberculin test a value of 100%, in discovering tuberculosis, the physical signs attain a value of much less than 1%. The pediatrist is now trained to look for his signs, if there be any, about the hilus region rather than in the apices; reversing the situation in adults. Dulness along the inner border of the scapula, of fine râles over this area, and, occasionally, a change in the breath sounds, may be all that can be elicited. In infants, especially with advanced lesions, the signs may be those of bronchopneumonia, and only the further course and other diagnostic aids, can prove the condition tuberculous. In the child, one may be guided toward the diagnosis of tuberculosis by presence of the so-called paratuberculous pro-

cesses; i. e., phlyctenular conjunctivitis, erythema nodosum and serous pleurisy. Take for example, the following case history: I have had under my care a girl who has had many recurrent upper respiratory infections. She never thrived, and whenever she caught any infectious disease, it ran an especially severe course. Her tonsils were removed and her diet corrected, but she still spent most of her winters indoors. During one of her attacks of so-called "grippe" typical lesions of erythema nodosum appeared. A Pirquet test was strongly positive, though a roentgenogram of her chest, a year previously, had been pronounced normal. Appearance of the erythema led us toward the correct interpretation of our problem and definitely stamped the patient as having tuberculosis.

In the same way, a pleural effusion, especially if unaccompanied by pneumonia, should always arouse suspicion of tuberculosis, and the physician is in duty bound to use the tuberculin test and should not be deterred from doing so because he fears to alarm the parents.

Another helpful lead in diagnosing tuberculosis is the finding of skin tuberculides; which, if not a common finding, are not extremely rare. A few years ago, when there were many cases of epidemic encephalitis about, I saw an infant of 2 years in whom a convulsion, stupor and meningeal signs had led to this diagnosis. The finding of several typical papulonecrotic tuberculides on the buttocks led to the diagnosis of tuberculous meningitis, which was proved correct by the finding of tubercle bacilli in the spinal fluid.

The presence of tubercle bacilli in the sputum of children is difficult to detect. The child does not expectorate but swallows his sputum. This has led to a systematic study of the gastric contents of fasting children. The work of Armand-Delille and his colleagues in France, of Opitz in Germany, and of Poulsen in Copenhagen, has definitely proved that this method is exceedingly useful. Shortly after the infant awakens, the stomach is washed with a small amount of sterile water. The contents are then examined in various ways. If masses of swallowed sputum are obtained, they can be put on a slide, stained, and directly examined. If no such masses are found, the material should be centrifugated and the sediment examined microscopically, and inoculated on proper media or injected into guinea-pigs. Though this method is somewhat complicated, it is productive of remarkable results. Opitz has shown that even in cases of perifocal infiltration, the gastric contents will show a positive reaction. Likewise, in cases of tuberculous meningitis without demonstrable general miliary dissemination, the gastric lavage contained tubercle bacilli in 100% of the cases. Friedlander showed that in 19 infants under 1 year, with positive tuberculin reaction, tubercle bacilli were found in the lavage in every instance. Wallgren has reported positive findings in a baby even before the appearance of fever and before any radiographic evidence was obtained. Frequently, one may obtain sputum by causing the child to gag while a tongue-depressor is held over the epiglottis. During the past few years tubercle bacilli have been reported, by Loewenstein, in the circulating blood, but it is still too early to evaluate those results.

By far the most useful diagnostic method is the tuberculin test. At the Mount Sinai Hospital, in New York City, on the Pediatric Service, a cutaneous tuberculin test is performed, routinely, on every child upon admission. If the test is positive, we know that we are dealing with an individual who has been infected with tubercle bacilli and that somewhere in his body he has reacted by the formation of tubercles. In other words, in such a child we cannot exclude the tuberculous factor as a cause for whatever ailment he may have. If, on the other hand, the test proves negative, we are not in a position to say that he may not have been infected with tuberculosis; for either he may be so overwhelmed by his disease that he fails to react to the skin test, or he may have so slight an amount of disease that he fails to react to so rough a test. Our custom is, therefore, if the Pirquet test proves negative, to perform an intradermal test, using either 0.1 or 1 milligram of tuberculin. If this last is negative, we feel that, in the majority of cases, the child is not tuberculous. If, however, the clinical symp-

toms make us suspicious of the presence of acid-fast disease, we repeat the Mantoux test, using 2, then 5, and finally 10 mg. of tuberculin.

Instead of using plain old tuberculin for the cutaneous test, Dr. Schick introduced the use of doubly-concentrated tuberculin; O.T. boiled down to one-half its volume, thus making the Pirquet test much more delicate. The Mantoux tests are made with plain freshly diluted O. T. We have found this to be a very satisfactory procedure. First, it is recommended by its simplicity; for, performance of the Pirquet test is certainly a very simple and fool-proof procedure, and in many cases it is not necessary to go on to performance of an intradermal test. Secondly, it is a safe procedure. In certain cases, intradermal injection, if not carefully dosed, may give rise to unpleasant local and general symptoms which are best avoided. To mention an instance, let me cite the case of a girl, 10 years old, suffering from serous pleurisy. A Pirquet test done on admission, when she was very ill, proved negative. Two weeks later in the course of her illness, as she was recovering, the intern was told to repeat the tuberculin test because we were suspicious that the condition was due to tuberculosis. He injected 1 mg. intracutaneously, instead of repeating the Pirquet test. This Mantoux test was markedly positive, and the child's temperature rose to 105° for a few hours and then subsided. After this, a Pirquet test was repeated in order to prove that the diagnosis might have been made without causing a general reaction. This Pirquet test proved positive. In other words, the safest procedure is to precede the Mantoux test by a Pirquet test, for in this way we can safely exclude the production of a severe reaction.

No one will deny that the cutaneous is less delicate than the intracutaneous test. In some institutions only the latter is used. When one is interested in ascertaining the presence of tuberculosis, not for clinical but for statistical purposes, I believe the Mantoux test must be used in preference to the Pirquet. For example, in 1916 I was interested in discovering how many children in a large infant asylum had been infected by tubercle bacilli. These children were, to all intents and purposes, healthy individuals. I proceeded to do a Pirquet test and found 3.3% positive. On the remainder, a second Pirquet test was done and showed 6.8% positive; a third Pirquet test showed 10.1% positive. A Mantoux test using 0.01 then 0.1 and last 1 mg. was performed. In other words, no child was considered free from tuberculosis until 6 negative tests had been recorded. Had I stopped after the first Pirquet test, I would have concluded that 3.3% of the children were infected, but by increasing the amount of tuberculin and using the more delicate intradermal test, I found that 25.2% were tuberculous.

By concentration of the tuberculin, as mentioned above, the Pirquet test is rendered more delicate and one of the main objections to its use is removed. Moreover, I think it is a very excellent test for office use. It is inconvenient to have to make up fresh dilutions when one needs to make a test, and besides, it is much easier to scarify the skin than to perform an intradermal injection. If, after this test, one is still in doubt, he can always do a Mantoux test, and, in so doing, there is very little likelihood of setting up a general reaction.

In a recent report on the study of almost 6000 children from the Lymanhurst School in Minneapolis, Stewart has shown the great value of the Pirquet test. Of 3981 children with a negative Pirquet test only 0.58% showed the more conspicuous lesions characteristic of childhood primary tuberculosis. Comparing the value of the test with that of the Roentgen ray, Stewart says: "If a value of 100% is assigned to the Pirquet test, as measuring its efficiency in the discovery of childhood tuberculosis, the x-ray examination has a reliable efficiency of about 25% and the physical examination an efficiency of a small fraction of 1%."

I have looked over the last 200 admissions to the Pediatric Service at our hospital and find that 25 children showed a positive tuberculin test. Of these, 14 reacted to a Pirquet test, while the remaining 11 needed various dilutions of intradermal injections to bring out the reaction. In 12, the tuberculin test indicated active tuberculous disease, proving the great importance of a routine test.

To correctly interpret the Roentgen-ray picture of a lung infected with tuberculosis, it is necessary to understand clearly the course of tuberculous disease. The whole question of pulmonary tuberculosis has been greatly clarified by the conception of various stages in the infectious process, so that a primary, secondary and tertiary stage may be recognized. Before taking up the actual Roentgen-ray interpretation, let us rapidly review the events that take place during pulmonary infection.

We know that in America, where the milk supply is carefully supervised and where children do not often receive infected milk, that the child is infected with tuberculosis almost in every instance by way of the lungs. Contact with tuberculous individuals is often ascertainable, and even a brief contact may result in infection. The germ enters the respiratory tract, settles in the lung and there produces a lesion. From the well-known studies of Ghon, Kuss, Hamburger and Opie, we know that in every instance a so-called primary focus is found. This may be located anywhere in the lung, but is usually situated in the lower lobes, most often on the right side. This focus varies in size from an almost microscopic area to that of a grape. It is usually single, but 2 or even more primary focal points may be present. Coupled with this lesion is involvement of the regional nodes, leading to swelling, inflammation, caseation and calcification. The whole pathology from here on depends on the amount of resistance shown by the child and his allergic response. Surrounding both the primary lung focus and the infected hilus nodes, we may see involvement of the parenchyma of the lung, the so-called perifocal infiltration which is of great diagnostic significance and which we will later discuss more fully. The primary focus and its related lymph nodes form together what Ranke called the *primary complex*. As the resistance of the average child is good, the primary focus usually, after a variable time, becomes firm and surrounded by a more or less dense capsule, and finally calcifies. In very young infants, whose resistance is less marked, the primary focus itself may fail to resolve and may undergo breaking down leading to a large area of caseation and destruction of lung tissue.

During the secondary stage, the tuberculous process may extend to other parts of the body and involve remote portions, such as the joints, bones, skin and other organs. At this time also the blood-stream may be infected and miliary tuberculosis result.

The third stage gives us the picture of adult pulmonary tuberculosis; due to re-infection, whether from within or without. The classical picture of phthisis results, with its apical involvement and parenchymal destruction, in the formation of cavities. It is supposed that this last type of reaction, on the part of the body, depends on the fact that its re-activity has been altered by existence of the primary infection.

Such is, in brief, the story of the progress of tuberculous pulmonary infection in a child. When we come to the diagnosis of these various stages on the x-ray plate, we encounter certain difficulties. The 2 main pit-falls are: (1) evaluation of shadows in the region of the hilus; and, (2) proper interpretation of so-called perifocal infiltrations. As to the hilus region, we now know that many illnesses, such as repeated respiratory infections, grippe, measles, pertussis, or sinusitis, may result in swelling of the hilus lymph nodes. The adenitis due to tuberculosis may result in the same type of shadow on the x-ray film. Stoloff says: "To diagnose tuberculous disease of the lymph glands roentgenologically, 3 factors are essential: (1) a patient with a positive tuberculin reaction; (2) a primary focus; (3) a pathologic hilum, or disease of the hilum glands". A very dense shadow, indicative of calcification, is evidence in favor of a tuberculous process.

Since there may be all gradations from a slight swelling of the hilus nodes to large calcified masses, it is evident that one may not depend on the x-ray appearance alone for diagnosis. In reviewing a large series of chest plates with 2 other men, both of whom had large experience in a reading of radiograms, I was struck by the frequent difference of opinion as to interpretation of hilus shadows. When not only the bronchopulmonary but the

paratracheal nodes are involved, tuberculosis is usually the etiologic factor.

The question of perifocal infiltration is one of great importance. About a tuberculous focus there is often seen a hazy area which may be circumscribed or may involve almost an entire lobe. It may be seen both in the primary and the secondary stage of the disease. In appearance, it often resembles a non-tuberculous pneumonic infiltration, and when it occurs with hilus tuberculosis it often takes the form of a triangular shadow with its base toward the hilus and its apex toward the periphery. It usually persists for weeks or months, and gradually subsides, leaving the permanent focus as a dense intrapulmonary shadow and the hilus nodes as characteristically tuberculous. This perifocal infiltration may appear and disappear several times in the same individual.

In 1916, together with Dr. Wessler, I described this appearance under the name of "Recurrent Hilus Infiltrations". Sluka, in Vienna, reported the same condition in the same year. Later, this phenomenon was described by Eliasberg and Newland under the name of "epituberculosis".

The first signs of pulmonary involvement may be the hazy shadows which Stewart speaks of as "resolving parenchymatous lesions". He found them present in 22% of his tuberculin positive patients at 2 years of age. Such a homogeneous shadow is confusing as to interpretation, for it is indistinguishable from a non-tuberculous pneumonia. Moreover, clinically, it may be accompanied by very few physical signs. Its importance lies in the fact that—when in a child with a positive test, one finds a homogeneous shadow involving sometimes an entire lobe, one should not rush to the conclusion that a large, serious lesion is necessarily present. Associated with this type of infiltration we often see involvement of the pleura. The interlobar fissure may appear as a thickened, horizontal line, and occasionally small interlobar effusions may be seen.

In later childhood, the adult type of tuberculosis may appear, and we see apical shadows and cavitation.

In these few remarks, I have attempted to put before you a review of the methods available for the diagnosis of tuberculous disease in childhood. Since tuberculosis is preventable, by excluding the child from contact; since it is curable only when recognized early; since it is one of our commonest diseases; and, since, in America, it is a disease which gains access to the body in almost every instance through the portal of the lungs; we, as pediatricians, should make every effort to perfect ourselves in the diagnosis of pulmonary tuberculosis in childhood.

DISCUSSION

Dr. Frank J. Altschul (Long Branch): We must bear in mind that tuberculosis in the infant is an infection occurring in *virgin soil,* in which allergy has not developed. Krause has compared tuberculosis in the infant to experimental tuberculosis in the guinea-pig. If a normal guinea-pig be inoculated with virulent tubercle bacilli, it may be noted that the bacilli appear in the lung in a few minutes but that they do not stop in the lungs; they travel immediately to the tracheobronchial lymph glands and localize there, causing lymph gland tuberculosis.

Dr. Bass has emphasized that the diagnosis of tuberculous infection in a young subject can be made with certainty but that it should not be made on the basis of an x-ray film alone, nor upon any other single procedure, but by careful study of the patient as a whole, including the history of contact, clinical symptoms, careful physical examination, tuberculin test, and x-rays. Dr. Bass did not mention study of the blood picture by means of the Sabin supravital stain technic and I should like to ask him what his views are on the importance of the lymphocyte-monocyte ratio as a help in diagnosis, and, especially, in determining prognosis.

I should like to emphasize the importance of obtaining a history of contact. This cannot always be readily determined. One fact that we must keep in mind is that infection does not always come from a member of the immediate family, but may come from a relative who visited the household for a short period, or from a servant or nurse who served a term with the family. Considerable detective work may be necessary to elicit the true source of infection but it can usually be accomplished. One reason for this peculiar attitude existing among the laity regarding this disease is, that it is looked upon as a disgrace to have tuberculosis in the family, and the matter is usually suppressed. Close questioning, however, will often disclose a chronic cough or "bronchitis" in some member of the household, where a flat negative reply had been given to the question of tuberculosis.

Another point which should be emphasized is that in these cases of childhood tuberculosis physical signs are usually absent. If we are to wait for physical signs to diagnose the condition we will fail in most cases. When râles and signs appear, the period most favorable for treatment has passed. Tubercle bacilli in the sputum are rarely found in the child except in advanced disease, and such cases usually go on to a fatal termination in spite of treatment. Further, it is our opinion that no dependence can be placed on gain in weight, normal temperature, or lack of symptoms in judging the process of disease in these young patients. If kept

in bed they will often put on weight, be afebrile, have good color, and feel well for a considerable time while the disease is steadily progressing. As Dr. Bass has shown, the appearance of the lesion as shown in serial radiograms, is the best available guide as to the real condition of the patient. It should be further emphasized that these films should be taken frequently, and treatment based on what they show rather than on the physical signs and symptoms, which are frequently misleading.

I was very much interested to hear Dr. Bass speak of the large doses of tuberculin that he used in his tests, and also that he used concentrated tuberculin. Recently, we have become interested in the use of *tuberculo-protein*. Our experience with tuberculo-protein is, so far, extremely limited and I should like to ask Dr. Bass if he has used it and what he thinks of it as against tuberculin for testing. The experimental and clinical work on tuberculo-protein has been done under the auspices of the Committee on Research, of the American Tuberculosis Association, in collaboration with the Mulford Laboratories, and tuberculo-protein is now available and sold under the name of "MA-100".

Tuberculo-protein is a fraction, as obtained by Masucci and McAlpine, from the filtrate of cultures of the human tubercle bacillus grown on Long's synthetic culture medium. Since this medium contains no protein, and only asparagin as the sole source of organic nitrogen, it follows that the protein found in the filtrate must have been synthetized by the tubercle bacillus itself. Parallel with the chemical and biologic studies, clinical trials have been made to test the practical value of MA-100. It has been shown that, as a diagnostic agent, it is as good and possibly better than O. T., in view of the fact that MA-100 is a pure substance as compared to the very complex composition of O. T.

If I may be permitted, I should like to read to you the Conclusions from an article entitled "The Present Status of the Skin Reaction in Tuberculosis", by E. S. Mariette and E. P. K. Fenger, in the March issue of the "American Review of Tuberculosis". The conclusions are as follows:

"(1) The MA-100 human protein is as sensitive and selective as O. T. and probably more so.

(2) The initial and repeat doses recommended for the MA-100 human protein are safe, in that dangerous reactions are not encountered.

(3) The initial and repeat doses recommended for the MA-100 human protein are large enough to pick out the majority of tuberculous individuals and apparently do not need to be increased.

(4) The MA-100 proteins are apparently not specific, in large doses at least.

(5) There is apparently a protein substance common to all acid-fast bacilli, which, if given in large doses, will elicit the same type of reaction as that obtained from O. T.

(6) As the MA-100 protein presents a substance in a purified form which can always be reproduced at the same isoelectric point, and which can be weighed in milligram doses, so that the exact milligram content of the solution is known, it is a better testing substance than O. T.

We have found the study of sufficient interest to recommend it to clinicians for further study. We believe that the sooner physicians begin to use the same substances and the same standards for determining the severity of reactions, the sooner will we get comparable results."

Dr. Marcus Newcomb (Brown's Mills): We gather from this paper that we cannot diagnose childhood tuberculosis from physical signs alone. We must take into consideration the family history and history of contact with the disease. If there is a history that the grandfather or grandmother had tuberculosis in Ireland or England, or some other place, that does not have much bearing on the present case. The question is, has that child been in contact with someone who has tuberculosis? There may be some difficulty in finding where the contact was made, but very often it will be with an employee of the household. A few years ago a Professor in one of the colleges said that one of his servants had developed tuberculosis. She had been in the household for 25 years and had a cough for many years. It is impossible to tell how many bacilli that servant may have scattered through his household. Certainly his children should have been examined at once.

The infection is determined by the frequency and the size of the dose of bacilli. The body will take care of a certain number of tubercle bacilli, provided they do not come too often or in too large doses. The history of pleurisy or of frequent colds must be taken into consideration.

After all, how are we going to get at the bottom of childhood tuberculosis? It is rather difficult to diagnose tuberculosis in childhood, especially in the rural sections where we do not have the facilities that Dr. Bass has in New York City. It seems to me that we must get at the bottom of this condition through the school children. While we have done a lot of work in tuberculosis, we have only scratched the surface, because even now the greatest number of deaths occur from this disease between certain ages. After all of our work and all of our improvements it is the greatest cause of death between certain ages; and I repeat I do not think we can attack this except through the school children and the school teachers. It is very important that every school teacher before she is allowed to sign a contract should have a thorough chest examination with x-ray. Only a few weeks ago I admitted several school teachers with far advanced tuberculosis. One of them had a large cavity at the apex of one lung and she had been teaching a primary grade composed of 30 or 40 pupils. She came into contact with all of the children in the school at the assembly, so that we cannot tell how many children will have a positive tuberculin test from that one teacher.

It seems to me that it is very important that we have healthy teachers or employees of the Board of Education and that we have healthy servants in our own homes. That is our work in the future in order to get control of tuberculosis; because if we expect to have healthy adults we certainly must have healthy children to start with. If we have this infection and do not recognize it, then certainly in after years many of these children will develop active disease and we do find adult-type of tuberculosis in children. I have a number of children in a sanatorium now, with far advanced adult tuberculosis, with positive sputum and with large infection in the lungs. We cannot do anything with these patients; they are simply doomed. Our only hope is in getting them early and I think our big work at this time is through the school children and those of pre-school age. All of our athletes and all of the athletic teams in schools should have thorough examinations. The experience in New York State has been that some of the most active cases of tuberculosis were among the athletes in the schools. We can only find this by a routine examination of all the children.

Dr. William London (Perth Amboy): I would like to ask Dr. Bass a question—whether he has had any experience with the multiple puncture, or Craig, test, and what is his opinion of its value as compared with the intradermal test? I have done a few of them and my experience is that they are more valuable than the simple von Pirquet.

Dr. A. S. Finkelstein (Newark): Dr. Bass mentioned using 10 milligrams in a second test. Is it his opinion that a repeated use of tuberculin will cause the skin to show a positive result in patients who do not show any clinical symptoms?

Dr. L. Charles Rosenberg (Newark): Will Dr. Bass, in closing, discuss the comparative value of tuberculin tests in children and in infants? I should also like to know how constant and reliable a finding is coughing as a symptom in children with tuberculosis.

Dr. Murray H. Bass (closing): I thank you for this discussion and I want to say that I am not a tuberculosis specialist. I have just spoken about tuberculosis from the standpoint of a man who has a general hospital service and who does general pediatrics. I put into this brief review only the things with which I have had experience. I have not had any experience with the new tuberculoprotein test.

As far as the school situation is concerned, I think Dr. Newcomb is absolutely right. It is a very important thing to weed out the tuberculous children as early as possible. I remember one instance where, at an infant's home, the tests were done routinely every 6 months. At one time there were no positive reactions in the ward but at the end of the next 6 months every infant was positive. It developed that one of the trained nurses had tuberculosis and had infected the whole group.

I have had no experience with the multiple puncture test.

Many different opinions exist as to whether repeated tests increase the sensitivity of the skin. I did some work along that line and it seemed to me that while we did get more positive reactions in that way, a stage was reached where we might go on indefinitely and not get any more positive reactions. Would that mean that some children have skins which can be sensitized? I cannot answer that.

I tried at one time to find whether the degree of cutaneous reaction might be influenced by the non-tuberculous protein in the testing fluid, and did many tests with a solution prepared from culture media without addition of the tubercle bacilli. None of these tests, however, gave positive results.

Two men (I think it was Casparis and Happ) at the Johns Hopkins Hospital, repeatedly tested tuberculous meningitis patients, and could always get positive tests if they used large enough doses of tuberculin.

A question was asked about the comparison of tests in children and in infants. The only thing that I can say is that the younger the child the more significant is the positive test. Just as Dr. Altschul said, the little baby is virgin soil for tuberculosis.

The amount of infection is important. If a person is just casually visited by a tuberculous individual, usually nothing happens, but if a child is being taken care of daily by a tuberculous person there is a great deal more chance of becoming infected and more seriously infected. Therefore, the younger the child the more important is the tuberculin test. As to the existence of cough, many tuberculous children do not cough at all.

RELATION OF FREQUENT COLDS IN CHILDREN TO DISEASES OF THE ACCESSORY SINUSES

Charles G. Kerley, M.D.,
New York City

Among the patients who come to me for special attention, respiratory infections hold second place—exceeded only by those who come because of gastro-intestinal ailments. It is our habit, with all new patients, to make a complete physical examination.

In respiratory conditions we have always paid particular attention to the sinuses and until the past 2 years we employed transillumination as a routine. Difficulty in using this measure on children in the younger groups, and frequent diagnostic errors on our part and that of consulting rhinologists who relied on transillumination, led us to abandon this procedure. We found that transillumination might reveal sinus involvement but the expected pathologic findings were not verified clinically or by radiography. We had not proceeded far in our x-ray undertaking when difficulties were encountered—the absence of normal x-ray standards in the young and the variations in effect within the normal as shown by the x-rays. We accordingly carried on x-ray studies in well infants and children in order to establish radiographically normal standards for the different ages.

Among 173 patients who came to us because of recurrent colds, sinusitis was demonstrated radiographically in 133. In 40, the sinuses were radiographically normal. Among those with positive findings: 1 was under 1 year of age; 17 between the first and third year; 25 between the third and fifth year; 54 between the fifth and ninth year; 36 after the ninth year.

The sexes were fairly evenly divided, 70 male and 63 female. All came because of persistent recurrent colds sufficient to be a disturbing factor in the child's life. What appeared particularly to interest the parents was the time lost in school attendance. In 79 the maxillary antrums were involved; 46 the antra

and ethmoids; 7 the ethmoids only; 1 the frontals only.

The degree of involvement was variable. In some there was a marginal edema, in others a complete antrum block evidenced by dense shadow. Between the 2 extremes there were varying degrees of involvement—the maxillary antrum was found diseased in 125 of the children. In 37, there was a block of one antrum or both. In 92, or 69.17% of the demonstrated sinusitis cases, the tonsils and adenoids had been removed.

Treatment—Both local and constitutional treatment were required, the local consisting of 10% argyrol solution on nasal tampons at 5 to 6 day intervals. Morning and evening the nostrils were douched with normal salt solution, employing the Birmingham douche for the older children, and instillation by means of a medicine dropper in infants and young children. Immediately before retiring, 4 drops of 50% adrephine solution was instilled in each nostril. For patients who failed to respond to local and constitutional treatment Eggston's stock vaccine was employed.

Constitutional measures consisted in the correction of digestive disorders, which included proper intestinal elimination, suitable diet, the avoidance of excessive sugar intake. For those with asthmatic associations, protein skin tests were employed. For those with a history of profuse nasal discharge, atropine in nearly physiologic dosage was brought into use. A warm bath at bedtime, followed by a cool shower, we found of assistance.

Secondary anemia or constitutional ailments, faulty life habits of any nature, such as pronounced malnutrition, were given suitable attention.

(Lantern slides were shown demonstrating the development of the sinuses and radiographic findings in those with sinus involvement.)

DISCUSSION

Dr. William J. Greenfield (Hackensack): It gives me a great deal of pleasure to discuss Dr. Kerley's paper, and to endorse everything he said. Furthermore, I have 29 slides which I would like to show, because they are of similar character. This work began about 4 years ago; when I tried it on some patients who did not respond to simple medical nasal treatments. I think the reason he has such good results is because his patients always follow his advice and remain with him longer under this form of treatment than they would remain with me, or with a younger person. This method of treatment takes time and patience to obtain results. (Dr. Greenfield also exhibited lantern slides.)

Dr. Arthur Stern (Elizabeth): Mr. Chairman: I have listened with a great deal of interest and pleasure to the remarks on this important subject which has been so vividly illustrated by Dr. Kerley. Those of us who have received their pediatric education in the Jacobi School are confronted by a peculiar observation, that is, the disappearance of lobar pneumonia and its replacement by these miserable infections of the upper air tract. A few years ago I spoke before this Society on the infections of the upper air tract, the glandular ring, the bronchial tree and the lungs in children, which confront us in December and up to late in May and June. The older physicians have been excellent clinical observers but probably they have not seen so many of these infections as we see today. Whether the great influenza epidemics have any bearing on these infections is hard to tell but there is one thing absolutely sure and that is that these infections do not give very much immunity to the children. On the other hand, they make the child more susceptible to relapses. How significant the rule of removal of tonsils and adenoids is has been shown in the National Congress of 1930 by Dr. Albert Keyser, of Syracuse, who read a paper on the observation of 4400 children who had tonsils and adenoids removed, comparing them with 4400 children who had not been operated upon. I remember very well that I met Dr. Keyser on the train going to Stockholm and remarked that I hoped he would give us something of interest to prevent these terrible infections in children. He was non-committal but I wrote down a few remarks from his paper which are very interesting.

(1) He states that head colds occur in 22% of tonsillectomized and in 20% of non-tonsillectomized children.

(2) Bronchitis occurs somewhat more frequently in children whose tonsils have been removed.

(3) Pneumonia occurs more frequently in tonsillectomized children.

(4) Sinusitis. First attacks occurred somewhat more commonly in children when tonsils and adenoids had been removed.

Dr. C. H. Schlichter (Elizabeth): I have long been of the opinion that we were working in the wrong direction, in treating these recurring colds in children by removing the tonsils and adenoid tissue; though I am not so sure about adenoids as I am that we have taken out a lot of tonsils for which we will have to do penance.

It is true, that a large percentage of the children with recurring colds have sinus infection which cannot be shown by transillumination, as Dr. Kerley said. In order to transilluminate and show a shadow, there must be a thickening of the tissue. Light will go through fluid pus but there must be changes in the mucous membrane or of the periosteum, and in some cases in the bone itself, in order that a shadow may be cast. So, I like to have a radiograph done by one who is skilled in that work. This is, sometimes, the only way that the condition can be diagnosed, although by looking into the nose and by shrinking the turgid mucous membrane and observing the discharge, the diagnosis can be made: often without transillumination or x-ray.

Maxillary sinus infection does occur early. We

have had in the Elizabeth General Hospital 2 patients with purulent nasal conditions, who were under 3 months of age, and it was necessary to operate on both.

As to treatment, I agree thoroughly with what Dr. Kerley is doing, but I like to use suction once in a while, where I believe I can draw the septic material out and that a better blood supply is brought to the tissue and increases the leukocytes. I would go one step further: I believe we should think more about prevention of these conditions in children. It was my privilege to serve 3 years with the late Abraham Jacobi. At that time the conditions were as Dr. Stern described them, but of late years we have all seen the recurrent head colds in children causing them to lose much time from school, which is the thing that brings most mothers to the pediatrician or rhinologist. I had the same sort of trouble with my own grandchild. Children live today in a superheated atmosphere, in steam-heated houses, whereas we had to break the ice in the bowl before we could wash in the morning. The humidity in the average American home runs between 3° and 6° when it should be 55°. That is where the trouble begins. Mother, father, sister and brother ride in subways and buses, go to movies where sunlight never enters and pick up many infections. The child has a mucous membrane that is dry, the resistance is lowered because the humidity of the school-room and home is too low, and the whole picture is set for infection. We must, therefore, go further than treatment. Pediatricians, rhinologists and general practitioners must think of what is causing these conditions. In the school-room the teacher probably wears so few clothes that she feels cold, due to rapid evaporation from the skin, and up goes the temperature to nearly 80°. Dr. Kerley, even if we are rhinologists, we have not forgotten our general medicine. We do use general treatment, and I think that without it we would fail.

Dr. Charles Gilmore Kerley (closing): The local treatment which has been referred to briefly consists in the introduction of 10% argyrol solution by means of a cotton tampon in each nostril. Here it is allowed to remain for 15 minutes—upon removal the tampon brings away a dram or more of thick tenacious mucus which apparently lessens the engorgement of the nasal mucous membrane, thereby helping to produce a patent ostium. Twice daily a nasal douche is employed, consisting of normal salt solution applied by means of a Birmingham douche. . For those with evidence of relaxation of the nasal mucous membrane with engorgement, atropine is used in doses ranging from 1/500 to 1/150 of a grain twice daily—care being exercised to maintain the dosage under physiologic effects.

The child with antrum involvement is made to sleep with the head on an even plane with the trunk—this means that the pillow is dispensed with—the dependent head facilitates, because of the peculiar position of the ostium, better antrum drainage.

Those with edematous, hypertrophied turbinates should have the benefit of surgical attention to these structures. The patients are not discharged or considered cured until the sinuses are found radiographically normal. In 5 instances we have been obliged to resort to the Eggston (Manhattan Hospital) vaccine to complete the cure.

Every child with sinus disease is given a complete examination and the subsequent correction of bodily or functional defects—if diseased tonsils and adenoids are present the sinus management is not taken over until they have been removed. Sinus disease in children is readily corrected by means that may be carried out in the average physician's office. Surgical procedures have been necessary with 2 of my patients who had acute ethmoiditis.

In closing, I wish to emphasize the readiness with which acute sinusitis is relieved and controlled in the young—likewise the necessity of nasal cleanliness—the daily douche of normal salt solution being equally important as the daily bath or cleansing of the teeth—perhaps more so. Who knows the bacteria that may be harbored in a viable condition in these apparently spacious cultural areas.

ALLERGIC DISEASES IN CHILDREN

Samuel Blaugrund, M.D.,
Trenton, N. J.

In recent years the term allergy, as it has been almost universally adopted, includes asthma and other conditions showing sensitization phenomena. Much has been written on the subject, and the need of studying allergy in children as a special class was recognized and acted upon, so that now many hospitals have well-organized clinics devoted to the treatment of children with asthma and other allergic conditions.

There have been many theories advanced concerning the basis of allergy, some classifying it as hereditary and acquired; others on the basis of protein sensitization; while Peshkin and his associates at Mt. Sinai maintain that allergy cannot be explained entirely on the basis of protein sensitization, because the sensitizing substances, in themselves, are merely exciting factors and not the basic causes of the symptoms. They state further that a patient in a state of physiochemical equilibrium is free from symptoms in spite of exposure. If any factor overthrows this governing mechanism, symptoms appear. Other authors regard the basis of allergy as a disturbed balance between the sympathetic and parasympathetic nervous system.

As in the study of any other disease condition, the history of a suspected allergic condition is very important. Inquiry should be directed at: its inception; the time it occurs; whether during the day or night; after a meal; summer or winter; whether it is related to sleep; its relationship to certain places and substances, such as contact with animals;

whether it occurs after vomiting or is accompanied by running eyes or sneezing; whether the child presents a history of infantile eczema or urticaria and now presents himself with asthma.

It is also important to inquire into the ante-partum history of the mother, especially her diet during this period. Many expectant mothers have cravings for certain foods, and Dr. Ratner, of Bellevue, reported a series of cases where excesses of certain foods during the ante-partum period were responsible for allergic manifestations in the children. He further elucidates, through a series of experiments on guinea-pigs whose placentas have the same permeability as the human, that the fetus may be sensitized *in utero*. Schloss and his co-workers advance the proposition that excesses of protein are not altogether broken down into amino-acids but that whole proteins can enter the circulation in an unchanged state from the maternal intestinal tract and thereby gain entrance to the fetal circulation. Therefore, under certain conditions, an infant with a predisposition for allergy may become actively sensitized *in utero* because of the mother's over-indulgence in a certain protein food during her ante-partum period. After birth, when coming in contact with this food for the first time, it will manifest some form of allergic phenomenon.

With the advent of protein skin tests, and with a careful painstaking history, plus a thorough physical examination of blood (eosinophil), tuberculin tests, urinalysis, and radiographs of the chest and sinuses, a large percentage of allergic diseases can be cured or definitely relieved. In the matter of protein skin tests, use of the cutaneous tests is preferable to the intracutaneous, even though the latter be more sensitive. Many vegetable proteins are difficult to obtain in a form soluble in physiologic sodium chloride solution but are soluble only in an alkaline solvent; but the latter is highly irritating, and when injected under the skin may cause a pseudo-reaction which may be difficult to interpret, and, in very sensitive patients, may produce a severe reaction. In consideration of these objections, it seems that for general use the cutaneous tests are to be chosen. However, in spite of all this, a certain percentage of persons will not respond. The last word has not yet been written on allergic diseases; as is evidenced by the enormous amount of literature on the subject.

Pollinosis or hay-fever is the commonest manifestation of allergy. Infants sometime show symptoms of rhinorrhea or conjunctivitis but such symptoms are uncommon till the third or fourth year. In this part of the country, the most common forms are the timothy and the ragweed groups of grasses; the former coming in the Spring and early Summer, the latter in the late Summer and Fall. Tree pollens and other weed pollens may be causal factors, and cutaneous tests should always be employed to determine various types of sensitivity.

Fortunately, this type of allergy lends itself to treatment by means of desensitization, with greater success than any other forms of allergy. The objective should be to increase the individual's tolerance, by means of pollen extracts, to the highest point before his season begins and maintain this through the pollinating period. Frequent intervals plus increasing doses is the method *per se*.

Installation of air filters in rooms have proved of some benefit by giving relief from wind-borne pollens.

Always keep your patient under observation for at least 20-30 minutes after each pollen injection.

Asthma. A classification of asthma that seems sufficient for practical purposes would divide cases into 3 groups: (1) Protein-sensitive asthma. (2) Protein non-sensitive asthma. (3) Para-asthma. Under para-asthma, such conditions as atelectasis of the lung, enlarged thymus gland with pressure signs, enlarged bronchial lymph nodes, and pathologic stenosis of the tracheobronchial tree should be considered. For these conditions, the radiographic and bronchoscopic considerations are necessary for diagnosis and treatment.

Elimination of all foci of infection, whether in the tonsils, teeth, or sinus and para-sinus structures; complete protein skin testing, as some cases show multiple sensitivity and it is

extremely important to determine all possibilities; plus such additional laboratory data as may be indicated; in conjunction with a careful inquiry into the history and the usual drug therapy; should give us a satisfactory therapeutic result. However, results are tangible depending on such factors as environment, nationality, age of onset, number of skin tests, etc. Ratner stresses the importance of environment and claims beneficial results by referring some patients to a convalescent home or special hospital ward, or to the seashore or mountain resorts. In extremely stubborn cases, Peshkin and his associates recommend ketogenic and low carbohydrate diets, on the assumption that you might restore the physiochemical imbalance previously considered.

Infections of the upper respiratory tract, such as rhinitis, sinusitis, nasopharyngitis, pharyngitis, tonsillitis, laryngitis, tracheitis and bronchitis, may be of infectious origin, but are frequently manifestations of respiratory allergy, or may be a combination of both. The most important point in the differentiation is—to think of allergy. The history may give you a lead, such as eczema, urticaria, gastro-intestinal vagotonia, asthma or hay fever. Attacks due to allergy are usually recurrent, while attacks due to infection usually confer an immunity of about 3 months and are definitely contagious and related to exposure. Most allergic cases with nasal symptoms present the symptoms of itching of the nose, throat or eyes. Those with bronchial symptoms give a history of wheezing. Infectious cases rarely present these symptoms. Smears from nasal discharges and sputum show predominance of polynuclear eosinophils, while in the infectious case the smears show a predominance of polynuclear neutrophils. It is a safe rule to regard a smear or nasal or bronchial secretion, showing 10% or more eosinophils, as diagnostic of allergy. Finally, epinephrine is specific for symptoms in allergic cases but gives little relief to those in the infectious group.

Eczema is the response of the skin to irritation, the source of which may be single or multiple; related to local infection; to cold, heat or light; or to intolerance of an allergic nature. If allergic, it may be sensitivity to food protein, carbohydrate or fat.

The following principles are stressed in dealing with eczema: (1) Prolonged cooking often reduces the ill effect of foods, for example; raw apple may give trouble, apple sauce may not. Evaporated or drying processes may, likewise, alter the offending fraction in milk. (2) Substitution of goat's milk, preferably evaporated (Alpure brand), is indicated when there seems to be a sensitivity to the lactalbumin of cow's milk. Also, Sobee has given satisfactory results provided there was no sensitivity to barley. (3) Since wheat is the most common offending cereal, rice, in any of its various forms, is the most generally accepted. Of course, graded administration of the offending allergen will usually increase the tolerance. Many local preparations have been recommended, and coal tar products have been very efficient.

Urticaria and angioneurotic edema. Usually a food allergy is identified by protein skin tests. Some authors note a lower calcium metabolism and advise calcium therapy, plus epinephrine.

Colic or vagogenic gastro-enterospasm. Some are allergic, others are not. Observations have been made of the frequent association of colic and eczema. These infants seem to tolerate sweet milk in preference to acidified milk, probably because of the hyperacidity associated with the hypermobility. Atropine seems to be of some benefit, plus various modifications of formula.

Allergic migraine. Balyeat, of the University of Oklahoma, reported a series of cases of allergic migraine in children with definite food allergy causes and observed that many cases of so-called cyclic vomiting in children may be migraine.

Conclusion. It is important to regard allergic phenomena in a child on a broad basis and to realize that these conditions, no matter how slight, should be studied most carefully, in order to put ourselves in a position to advise the mother properly, as to management of the child, and to assist in the work of preventive medicine in this, as in other fields.

DISCUSSION

Dr. Arthur Heyman, (Newark): This timely paper gives us a clear view of present-day knowledge concerning allergy in children. No one who treats children can doubt the importance of sensitivity in the etiology of a wide range of disturbances. However, we must not lose sight of the fact that bacterial infection still plays a major rôle in exciting disease, although in some infections, e. g., rheumatic fever, some of the symptoms may be due to allergic reaction to the bacterial protein. Other conditions may be traced to allergy while their later symptoms are apparently due to secondary infection. G. T. Brown, in the current number of our State Journal, claims good results from the use of stock mixed "cold" vaccines in addition to specific pollen extracts in the treatment of seasonal hay fever.

The protein skin tests, of course, have proved invaluable in clarifying many cases of allergy, but there are still some children with undoubted sensitivity disorders, who are either negative to all indicated tests or react positively to so many foodstuffs that withdrawal treatment is practically impossible with concomitant starvation. So, too, in the very young infant, positive skin reaction to substances that could hardly be associated with this age group was difficult to explain until the work of Ratner, noted by Dr. Blaugrund, so clearly showed the path of sensitization through the single-layered maternal membrane.

Discussing upper respiratory infections, Cohen and Rudolph state: "Many physicians do not think of allergy in relation to these conditions unless the symptoms are typical of hay fever or bronchial asthma, and some even consider typical asthmatic attacks to be infectious in origin because in some children they are accompanied by fever. Such a stand is now untenable."

Finally, it is important to note Balyeat's statement in this week's Journal of the American Medical Association that "One may become specifically sensitive to foods or other substances and the manifestation occur only in one tissue of the body, as in allergic episcleritis". This authoritative dictum supports Dr. Blaugrund's inclusion of migraine, colic and other isolated entities as possible allergic phenomena.

TREATMENT OF BONE TUMORS

Milton Friedman, M.D.,

Assistant Radiation Therapist and Research Fellow in Cancer, Bellevue Hospital, New York City, and Associate Roentgenologist in Charge of Tumor Clinic, Beth Israel Hospital,

Newark, N. J.

The medical profession thankfully heralded Codman's classification of bone tumors because of its very efficient correlation and simplification of a large number of chaotic categories. This classification is workable so far as non-osseous tumors of bone (giant cell tumor, multiple myeloma, endothelial myeloma) are concerned. The inclusion of all osteogenic sarcomas under one heading sufficed so long as the only available therapeutic procedure was radical surgery. With the perfection of radiotherapy, however, it became necessary to remove certain more or less radiosensitive, osteogenic sarcomas from the range of the radical scalpel, and subject them preoperatively or exclusively to the influence of radium and x-rays. These exact types of osteogenic sarcomas are in the process of clarification at present, which process is being amplified by the additional information derived from the study of the susceptibility of these tumors to radiation therapy.

Kolodny, and also Copeland and Geschickter, in their recent books on bone tumors, have offered separate groupings, the accurateness of which is still to be proved. Nevertheless, both monographs present their facts and conclusions so ably, that they demand authoritative recognition or honest divergence of opinion, thereby stimulating progress. I am able this afternoon to present examples of every type of bone tumor which may be compared individually with the accepted standards of diagnosis and treatment, thus permitting a comparative estimation of the validity of the present classifications.

The tumors to be discussed are: (1) Multiple myeloma. (2) Endothelial myeloma. (3) Giant cell tumor. (4) Chondroma. (5) Osteogenic sarcoma.

Multiple Myeloma

This is a tumor of adults. The geographic sites of origin coincide with the important erythroblastic centers in bone (spine, skull, ribs, sternum, and upper femur). Its cytogenetic derivation stems exclusively from bone marrow cells. These factors would tend to deny this as a true bone tumor, except for the fact that, as the tumor progresses, it continues to concern its distribution essentially with bone, either by metastasizing to other bones, or by gradual transposition-involution of bone marrow to neoplasm. As growth continues, the tumor negates the innocent tendencies of its progenetic cell, and dissolves bone. This gradually devastates the skeletal framework.

Clinically, the lesion originates in the spine, skull, femur, or ribs. It first manifests itself

by the production of pain, presentation of a mass, or pathologic fracture, and is accompanied by neurologic manifestations such as radiculitis or paraplegias. Roentgenographically, one sees multiple, central, osteolytic areas in the bone, without a reaction zone; the process fading rapidly into normal. Bence-Jones protein is found in the urine as the result of an associated nephrosis.

Pathologically, the tumor is composed of cells resembling the plasma cell. Aside from the fact that the tumor cell is probably a derivative of the reticulo-endothelial system, the exact origin of the neoplastic cell is unknown. It is probably a local tissue histocyte with the function of plastic repair, which has undergone neoplasia. The moderate degree of radiosensitivity confirms the relationship of this tumor to the hemopoietic system.

Case 1. This patient, a man 60 years old, had a typical tumor originating in the second cervical vertebra and manifesting itself clinically as a dislocated neck due to destruction of the vertebra body, with compression and partial subluxation. In 6 weeks after the institution of x-ray therapy, he was able to dispense with the brace supporting his neck. In spite of clinical improvement in this area, the disease spread to other parts of the body and caused pain, which would in turn disappear under further radiation. Repeated roentgenograms revealed continued wide-spread involvement of all the bones of the body. We were confronted with the exasperating paradox of temporary disappearance of pain and weakness with improvement in general health and gain in weight, while at the same time there was actual rapid progression and metastasis of the disease.

Bence-Jones protein in the urine has been accepted as a positive test for multiple myeloma, but it is present in only 70% of all cases, and may be present occasionally in other bone and blood cell tumors; resulting from a nephrosis with tubular degeneration.

To summarize, multiple myeloma is a fatal disease of the erythroblastic bone marrow, occurring in adults. While there is no definite cure, radiation offers a slight prolongation of life, considerable alleviation of pain, reduction and walling-in of tumor masses, prevention of pathologic fractures, and healing of those which have occurred. The average length of life from onset of the disease is 2 to 2½ years.

Endothelial Myeloma (Ewing Tumor)

This very complex tumor is analogous to multiple myeloma in that it is derived from a primary reticulo-endothelial cell, but its clinical course more clearly simulates the conduct of a true primary bone tumor. The exact nature of the tumor is still unproved histologically, the adult cell resembling that of lymphosarcoma. It is round, or somewhat polyhedral, with scattered chromatin granules, and is much paler than the lymphoblast. There is practically no intercellular stroma, the tumor consisting of a massive aggregation of cells. Multinucleation does not occur. Of greatest importance in confirming the similarity to a lymphoblastoma is the fact that this is one of the most exquisitely radiosensitive tumors known, which factor is also the most conclusive diagnostic test. Inexplicably curious is the fact that the tumor does not arise in the myeloid cavity itself, but in the haversian system in cortical bone. It expands the cortex, comes to lie sub-periosteally, and incites the construction of a reactive capsule of sub-periosteal and endosteal bone. It is only later in the course of the disease that expansion of the cortex reaches a peak, and then destruction ensues. In contradistinction to bone cyst, giant cell tumor, and metastatic carcinoma, this tumor seldom produces a pathologic fracture. These other tumors produce central destructive erosion of the bone by early lysis.

Case 2. This case of Ewing tumor of the spine presents many typical features. It occurred in a 14 year old boy, and originated in the second lumbar vertebra, which is a rather uncommon site; the more common location being in one of the long bones, particularly the tibia. The tumor itself soon surpassed the boundary of its bone of origin, and expanded bilaterally, forming 2 paravertebral masses each about the size of a grapefruit. Under the influence of small doses of penetrating radium gamma rays, these masses disappeared completely, and there was temporarily restored to the patient a fairly well-functioning spine.

Characteristically, the first metastases appeared in the skull and the lungs; then, in the neighboring lymph glands; and finally, spread throughout the entire body.

Microscopic examination of the specimen removed from the spine revealed typical cells of endothelial myeloma. They resembled pale-staining lymphoblastoma cells, in an alveolar arrangement due to circumscription by stromatous septa. Around the tumor cells could be seen the osteitis-fibrosa structure of the reactive bone.

The nature of Ewing's tumor is still debateable. It is not a bone marrow tumor, since it arises intracortically and does not immediately dissolve bone, as the narrow tumors do. It resembles, in its histologic picture and radiosensitivity, a lymphoma; being more radiosensitive than a true endothelioma. Ewing's latest suggestion is that the tumor is an angioblastoma.

In the flat bones or vertebrae, it adopts no characteristic appearance, and the only tentative, pre-operative diagnosis that can be made is a malignant tumor of the bone. Frequently, the microscopic examination of a specimen removed for diagnostic purposes complicates, rather than clarifies, the diagnosis because the endothelial myeloma may be atypical. This often leads to different diagnoses of the microscopic section by different pathologists.

Radiotherapy in these cases serves the useful purpose of providing a therapeutic test, which is an almost infallible test of endothelial myeloma. The administration of a 75% S.E.D. of high voltage x-ray therapy will cause in a few days a prompt partial or beginning regression of the tumor. If the tumor does not respond to x-ray therapy it is not an endothelial myeloma, even though it may have characteristic radiographic or histologic pictures.

Giant Cell Tumor

This complex tumor, most often found in patients in the second and third decade of life, may be defined as a central, expansile tumor occurring on the metaphysial side of the epiphysial line. It is a multilocular, cystic tumor, traversed and subdivided by bony trabeculae, and characterized histologically by a preponderance of giant cells. It is essentially a benign tumor, but may, and often does, recur locally following thorough surgical excavation. A few rare cases recur as giant cell sarcoma; and still more rarely, an occasional one may originate as a true giant cell sarcoma. It is a very difficult tumor to treat for the reason that it is curable, the cure depending upon the utmost delicacy in choice of the therapeutic procedure and the thoroughness with which it is applied. This important selection of treatment depends upon the type of the giant cell tumor. To classify properly the particular lesion, one must consider and analyze the clinical, roentgenographic, and histologic pictures.

Certain giant cell tumors are best treated by curettement and chemical cauterization of the residual bone cavity; some, by radiation; and others, by resection and amputation. A clinical failure in a curable case is an indictment against the procedure selected.

Histogenetically, the giant cell tumor is related to the absorption of calcified cartilage of the long bones of the adolescent and young adult by the giant cell osteoclast, prior to the laying down of adult lamellated bone. These giant cells overstep the bounds of function into the realm of hyperplasia, and finally neoplasia. Trauma is a frequent exciting factor. The giant cell epulis of the jaw is related to the loosening of the deciduous teeth by odontoclasts (giant cells), and consequently is commonly found in adolescents.

Some believe that these are not neoplasms, but represent an unhealed stage of osteitis fibrosa cystica; the latter process representing a healed stage. Others assume that these are the same processes, but that osteitis fibrosa cystica occurs in an earlier age at the metaphysial region, where ossification is in progress on the metaphysial side of the epiphysial line; whereas the giant cell tumor is commonly found in the epiphysis itself. Since the epiphysis ossifies at a later age than the metaphysis, the giant cell tumor occurs at a later age than the bone cyst.

Histologically, the more malignant type of giant cell tumor is one in which rapid growth prevents complete cell differentiation, and produces a cell lower in the evolutional scale than the giant cell; i. e., the spindle cell fibroblast.

The stroma resembles a spindle cell sarcoma, and the giant cells appear as an amorphous aggregation of these spindle cells. The more benign types have large, well-developed giant cells, with round, pale-staining nuclei, averaging 20-40 to the cell; and with a stroma of small, pale, round cells supported in a reticular network, and being quite vascular.

Roentgenographically, the more malignant, border-line, giant cell tumors grow rapidly, induce the production of little or no reactive bone capsule, permit no reactive bone trabeculae to form, break through the cortex, and invade soft tissues. They may even resemble an osteogenic sarcoma of the osteolytic type.

Clinically, the most malignant types occur more often in weight-bearing bones such as the tibia, and lower and upper ends of the femur. They frequently recur after curettement, and are radioresistant.

The term, malignant, is used in the above paragraphs to indicate a trend, but not actually to delineate a proliferating, metastasizing neoplasm. The true malignant giant cell sarcoma is an osteogenic sarcoma of the giant cell type that metastasizes as a spindle cell sarcoma.

The following are type examples:

Case 3. This roentgenogram reveals a giant cell tumor of the ileum in a 26 year old girl who complained of pain in the back. As you can see, it is a large trabeculated tumor with a heavy border of reactive bone. It typifies the benign type which, by its slow growth, permits nature to set up a circumscribing bony capsule, and honeycombs it with trabeculae of similarly functioning bone. Under high voltage x-ray therapy, giving a dose of 60% S.E.D., there resulted an immediate reaction of pain, swelling, and limitation of motion, followed in a few days by a fairly rapid subsidence of all symptoms over a period of 3 weeks. In 2 months, there was roentgenographic evidence of beginning healing. It is worthy of note that the final roentgenogram of this arrested lesion, as is the case with most healed giant cell tumors, revealed the same cystic architecture of the bone, but the cyst walls were heavily fibrosed, and the soft tissue shadows of the intracystic tumor tissue were absent. There is rarely ever seen complete healing of the involved bone, and replacement with new, normal bone. This tumor is a radiosensitive type, ordinarily inoperable and fatal, in which there resulted such a rapid response to a small dose of x-ray therapy, that the progress was arrested in 2 months. The roentgenographic picture of the healed lesion outlined in detail the previously active neoplasm.

The next 3 patients demonstrated postoperative recurrences of giant cell tumors. It is characteristic of this neoplasm that incomplete surgical removal is promptly followed by a recurrence, which is more persistent than the original lesion, occasionally acquires malignant characteristics, and is seldom curetted successfully a second time. Its cure is possible only by resection of the involved portion of the bone, or amputation of the limb. Fortunately, in many cases, the postoperative recurrence can be controlled by radiation therapy.

Case 4. This first case, in a 34 year old woman, is one of a recurrent giant cell tumor of the coccyx, which had been previously removed and the tumor bed curetted, but it recurred, the recurrence evidenced on the roentgenogram as an irregular, mottled shadow causing a ragged osteoporotic invasion of the lower end of the sacrum. A dose of 175% high voltage x-ray therapy was administered to the tumor itself, and it receded slowly and has remained quiescent.

Case 5. A giant cell tumor in the lower end of the tibia in a 26 year old man. It is a typical trabeculated tumor in a weight-bearing bone, which appeared shortly after an injury. Curettement and chemical cauterization were insufficient to prevent a recurrence which destroyed the entire lower end of the tibia and induced a pathologic fracture. A dose of 275% S.E.D. high voltage x-ray therapy was administered in divided doses to the center of the tumor over a period of 3 weeks. Regression was slow, and did not commence until 1 month after treatment was completed, and required 2 additional months before the patient was able to dispense with the support of a cane and crutch. From the final roentgenograms, we can see that the eventual healed bone is a maze of fused cysts with irregular, dense, osseous borders, but without any evidence of osteoclasis. The microscopic picture reveals large, well-formed giant cells with

centrally placed, uniform nuclei of the same character as the stroma cells, which are reticular in nature, containing round, light-staining nuclei with fine chromatic granules. The stroma cells are loosely held together by a reticular network of their own branches. This microscopic picture of benignity was confirmed by the clinical radiosensitivity.

Case 6. The third case of postoperative recurrence appeared in the lower end of the femur in a 16 year old girl. From the onset there was very little trabeculation in the tumor, but chiefly an expansile, osteolytic process exhibiting no elements of reactive bone encapsulation. The tumor rapidly invaded and broke through the bony cortex. Microscopic examination of the tissue obtained from the curettement revealed numerous small giant cells, which were polyhedral in shape, and contained very few (3-8) nuclei. These giant cells were often irregularly fusiform in shape as though formed rapidly by lateral cohesion of several stroma cells. The stroma itself was cellular and contained little intercellular substance. Its cells were spindle shaped with small, hyperchromatic nuclei. In general, it indicated a close resemblance to a spindle cell osteogenic sarcoma, though it was by no means malignant. The tumor recurred shortly after curettement, and continued to destroy bone, so that a pathologic fracture soon occurred. The patient was then referred for radiation. Intensive radium pack therapy was administered over a period of 2½ months, but it served to retard only slightly the destructive influence of the growth. An amputation was finally advised.

Because the histologic picture indicated a malignant trend, the lesion recurred even after a thorough curettement. The recurrence proved to be as radioresistant as would a similar spindle cell osteogenic sarcoma. Because of the anticipated radioresistance, it might have been wise to amputate early, and not subject the patient to prolonged radiotherapy that was doomed to failure, but as exceptions to the rule are common in radiotherapy, it was probably wise to subject this lesion to destructive rays for a trial period of 6 weeks.

Another factor which modifies the prognosis of a giant cell tumor is its location. When present in a weight-bearing bone, such as the femur or tibia, the tumor is subjected to continuous, repeated, mild trauma from the jarring of the body when walking, and such irritations aggravate the growth's virulence.

Case 7. This is the case of a giant cell tumor of the head of the femur in a 26 year old girl. The roentgenogram reveals an osteolytic lesion with no trabeculation or tendency toward encapsulation. This augurs a more malignant type of growth. Biopsy, with microscopic examination of the specimen, contradicts this prophecy by presenting a picture of utter benignancy; i. e., multiple, large, well-formed giant cells with clear, pale-staining cytoplasm, and numerous well-formed nuclei (20-40 to the cell). The stroma is cellular, though the cells are round, with pale nuclei, and a normal amount of reticular network. This patient was irradiated while ambulatory, but the lesion progressed, causing increasing pain and disability. Therefore, the hip-joint was immobilized in a cast, thereby eliminating trauma, and irradiation continued. The lesion slowly but surely regressed, as was manifested by increased calcification in the growth, but the process covered many months.

The malignant giant cell sarcoma is a rare lesion. It is not yet definitely proved that a giant cell tumor may become truly malignant and metastasize. Those which do, metastasize as a spindle cell osteogenic sarcoma. It is the contention of some pathologists that the tumor originates as a spindle cell sarcoma with incidental giant cells, which latter are absent in the more undifferentiated metastatic foci.

Case 8. This is a case of an osteolytic osteogenic sarcoma of the lower end of the femur in a 60 year old man, according to the roentgenograph. Microscopic examination of bits of tissue obtained by needle-punch biopsy showed a very interesting picture. Incidentally the clarity of the microscopic picture is a tribute to this method of biopsy. In one area is seen a highly malignant, compact, cellular spindle cell sarcoma; in other areas, schisms appear between groups of spindle cells, breaking off from the mother group of cells as small aggregations that resemble, and actually are, giant cells. The evident derivation of these giant cells is assurance that they are not inci-

dental, but are true tumor giant cells originating from the stroma, and by their osteoclastic function rendering this a bone-dissolving tumor. As was evident in the other giant cell tumors with a spindle cell stroma, the tumor was staunchly resistant to various, vigorous, therapeutic assaults by continuous, repeated radium pack therapy, and the leg was amputated. The patient is well 1 year after the operation. We may prophesy that if this tumor metastasizes, it will do so as a spindle cell sarcoma.

Conclusions Concerning the Treatment of Giant Cell Tumors

(1) True giant cell tumors occur most often in the third decade. Those occurring prior to or after that time are frequently atypical.

(2) Giant cell tumors in patients under the age of 20 are frequently related to osteitis fibrosa cystica; they may be present as giant cell variants of a bone cyst or may be multiple as a result of a parathyroid tumor.

(3) Malignant giant cell tumors may be derived from incompletely treated benign giant cell tumors; or may originate as spindle cell osteogenic sarcomas whose accompanying giant cells are derived from unit cohesions of groups of spindle cells.

(4) Giant cell tumors are best treated by radiation. Failure of a tumor to respond after 6 weeks' trial should suggest immediate surgery.

(5) Proper surgery entails thorough curettement of the bone tumor cavity down to normal bone, followed by thorough chemical cauterization with phenol or, preferably, 50% zinc chloride.

(6) If the radioresistant lesion has malignant tendencies, as exemplified roentgenographically by an osteolytic process with no trabeculation and destruction of the cortex, and histologically by a spindle cell stroma and irregular, scant giant cells, then resection and amputation should be performed.

(7) A recurrent giant cell tumor that shows no response to radiation in a trial period of 4 to 6 weeks should be resected or amputated.

(8) The degree of resistance of the tumor to radiotherapy depends upon the cellularity of the stroma and the resemblance of these cells to sarcomatous spindle cells.

(9) A tumor in a weight-bearing bone is more difficult to eradicate than one in a dependent bone.

Chondroma

This is a benign lesion which is being considered here because so many are helped by radiation, which may be administered primarily or postoperatively; and, secondly, because they commonly undergo malignant changes and become secondary chondrosarcomas.

Chondroma occurs most frequently in the phalanges as a central lesion of the bone (enchondroma). The treatment consists of curettement and cautery, followed immediately by intensive radiation.

Here are 2 cases of chondroma of the phalanges which were referred for radiation postoperatively. Both patients are physicians, and about 30 years of age.

Case 9. This one failed to respond to radiation and had to be resected; due, in part, to the fact that the patient appeared for radiation several months after the operation, at which time the recurrence had grown to a larger size than the original lesion.

Case 10. The other, radiated intensively, healed but he was referred for radiation immediately after the operation wound healed.

Chondromas occurring in the ribs, sternum and pelvis frequently remain clinically and histologically benign and do not metastasize, but are usually fatal because, by growing to a tremendous size, they compress vital organs. When irradiated, the superficial strata of the neoplasm become arrested, but deeper parts of the tumor, which receive only a fraction of the amount of radiation administered to the skin, continue to enlarge.

Case 11. This chondroma of the sternum in a 57 year old woman, bulged externally as well as into the mediastinum. Under radium pack therapy, the external protrusion disappeared but the mediastinal extension expanded. It underwent a healing calcification under the influence of therapy, but this served only to retard the rate of growth. It finally compressed the heart and caused death.

Chondromas frequently become malignant, especially after surgical intervention. This is evidenced histologically by an increase in the quantity of myxomatous tissue interspersed between strands and masses of cartilage cells. These lesions are often located in parts of the skeleton which do not permit resection. Fortunately, however, the administration of large quantities of heavily filtered radium and x-rays will occasionally control the growth.

Case 12. This chondroma of the ileum in a 48 year old woman was treated for 1 month with x-ray therapy. It continued to grow. A needle-punch biopsy revealed an adult chondroma interspersed with a few strands of myxomatous tissue, indicating a malignant trend. Radium pack therapy was then administered. After several months, the growth was finally checked, and soon irregular calcific deposits appeared throughout the lesion.

To summarize. Chondromas originate as benign tumors, and should respond to thorough curettement and chemical cauterization followed by radiation. Recurrences should be intensively irradiated, and if that fails, resected or amputated. Wherever there is any doubt of its benignity, the tumor should be curetted for fear of inducing malignant changes.

Osteogenic Sarcoma

Osteogenic sarcoma is the only true malignant bone tumor of bone cell origin. The wide variety of changes which the adult bone cell undergoes during the course of its evolution from the primitive, embryonal osteoblast is reflected in its neoplasms which comprise fibroblasts, myxoma cells, and spindle, round, cartilage, giant, and adult bone cells in varying combinations, which loosely follow rules based upon age, predisposing factors, geographic locations, and the portion of the bone involved. This complexity does not, however, modify the choice of therapy once the roentgenologist has made a diagnosis.

The best method of treating osteogenic sarcoma is immediate, radical amputation, with the exception of chondroblastic osteogenic sarcoma. The latter is a very malignant tumor, but, because of its radiosensitivity, it may be exclusively treated with radiation alone. It is unwise to amputate for an osteogenic sarcoma located at the upper ends of the femur or humerus, because there has been no reported cure in this location.

Classification. The existence of multitudinous, confused classifications of osteogenic sarcoma is a testament to our incomprehension of its histogenetic derivation. The individual types are well known, but their exact location on the evolutional scale of the bone cell is vague.

Copeland and Geschickter, in their recent book on "Tumors of Bone", have deduced a rational working classification of osteogenic tumors, which has been adopted here. Their premise is that osteogenic sarcomas are exaggerations or perversions of the normal processes in maturation of the adult bone tissue from the embryonal, pre-cartilaginous connective tissue. In this embryonal scale, there are 2 groups of bone tumors: (1) those originating from pre-cartilaginous connective tissue which forms the membranous flat bones of the skull, and the infantile calcified cartilaginous bone; and (2) those arising during the course of subsequent absorption of the calcified cartilage with the formation of adult, lamellated cortical and cancellous bone. Corollarily, the skeletal and age distribution of these tumors is of vital diagnostic importance.

Fibrocartilaginous group. The original embryonic connective tissue which has the power to form membranous bone or cartilage is particularly evident about the joints. Here they give rise to:

(1) Exostoses (osteochondromas), and chondromas.

(2) Secondary chondromyxosarcoma—arising from malignant involution of either of the above.

(3) Primary chondromyxoma.

(4) Sclerosing (osteoblastic) osteogenic sarcoma.

Adult group. These arise as a result of the exaggerated process of absorbing calcified cartilage in the long bones, preparatory to the laying down of adult lamellated bone.

(1-2) Giant cell tumors and bone cysts; products of the bone-dissolving osteoclasts.

(3) Chondroblastic osteogenic sarcoma arises from proliferating cartilage cells on the

shaft side of the epiphysial line as the bone grows in length.

(4) Osteolytic osteogenic sarcoma. (Malignant bone aneurysm; telangiectatic osteogenic sarcoma.)

This type arises within the marrow cavity of the long bones. In the wake of the absorbed calcified cartilage, the adult endosteum proceeds to form the cancellous bone of the marrow cavity with the help of the spindle cells of the endosteum and the osteoblasts in a vascular medium. The store of calcium from the calcified cartilage, having just been removed by the giant cell osteoclasts, there results a fundamentally non-calcifying osteolytic tumor. It is very cellular, contains giant cells, and spindle cells, and is very vascular. It occurs commonly in the third decade, because it is a perversion of an adult function in the chronologic development of bone. The sclerosing osteogenic sarcoma and chondromyxosarcoma arises in the younger group because of perversions of an earlier osteoblastic embryologic step.

Case 13. This first case is a typical osteolytic osteogenic sarcoma (or, as named by Ewing, telangiectatic osteogenic sarcoma) occurring in a 29 year old man, who complained of pain for 6 months before examination. The roentgenogram revealed a destructive lesion of the lower end of the femur with extension into the soft tissues. There is evidence of bone filaments extending into the soft tissues, which is so characteristic of osteogenic sarcoma. Intensive radiation with radium and x-rays was administered for 6 weeks, and after this trial period, another roentgenographic study was made. It was noticed that the tumor had shrunken slightly and there was some increased calcium deposition distributed irregularly throughout the tumor but not enough to prognosticate a future arrest of the process by further radiation. The leg was amputated. Pathologic examination revealed a vascular tumor which was very cellular, containing spindle cells, irregular giant cells, and many osteoblasts surrounding small areas of abortive bone. All these factors are slight perversions of the endosteal production of cancellous bone. This type of tumor is very highly malignant, frequently causes pathologic fractures, rarely responds to radiation, and should be amputated early.

Case 14. This next is a chondroblastic osteogenic sarcoma of the sacro-iliac joint, in a 26 year old man who presented a tumor the size of a fist over the right sacro-iliac joint. This tumor, like the osteolytic osteogenic sarcoma, is associated with the subsequent cartilaginous growth in the formation of adult mature bone. It is an exaggeration of the function of proliferation of the cartilage at the epiphysis as the bone lengthens. Needle-punch biopsy revealed a highly cellular tumor composed of embryonal chondroblasts. The tumor was very radiosensitive and melted away completely under radium pack therapy in 1½ months, though it was more than a year before there was any roentgenographic evidence of regression. This is the only radiosensitive type of osteogenic sarcoma.

Case 15. This next case is one of sclerosing osteogenic sarcoma, in a girl 9 years old, situated in the lower end of the femur. This is a type of tumor that is derived from the precartilaginous connective tissue and is a product of the osteoblasts. It presents the typical, shaggy, irregular shadows due to calcium deposition throughout the tumor by the osteoblasts. It showed no response whatsoever to radiation during a trial period of 4 weeks, and the limb was amputated; the usual fate of all sclerosing osteogenic sarcomas.

Factors Influencing the Treatment and Prognosis of Osteogenic Sarcoma

(1) Prognosis depends upon the degree of malignancy of the tumors.

(2) The slow-growing tumor is usually of osteoblastic type; which is manifested roentgenographically by striated or flocculent shadows distributed throughout. Some authors have reported 20% 5-year cure rate in this group.

(3) There appears to be no additional risk incurred by subjecting a bone tumor to a short trial period of radiation.

(4) In most cases, diagnosis can be made roentgenographically, thus precluding a biopsy. If diagnosis be in doubt, a frozen section biopsy should be made with the permission and provision for an immediate amputation.

It is mandatory to minimize the time between an incisional trauma and amputation, because loosened tumor cells might be transported to distant organs in the interim.

(5) There are appearing many advocates of local resection of certain slow-growing osteogenic sarcomas and secondary chondromyxosarcomas. Though future experiences may prove this method tenable, it is, nevertheless, a reckless procedure.

(6) No osteogenic sarcoma of any type should ever be curetted.

Conclusions

(1) Of 8 types of primary bone tumors, 4 are radiosensitive in varying degrees. They are, in the order of their radiosensitivity: endothelial myeloma, multiple myeloma, giant cell tumor, and chondroblastic osteogenic sarcoma. This fact is helpful when employed as a therapeutic test to aid diagnosis in a doubtful case.

(2) Radiation therapy should be discontinued in favor of surgery if definite results are not obtained in 6 weeks.

(3) Malignant bone tumors are curable under proper therapy. The more differentiated the tumor (i. e., sclerosing osteogenic sarcoma), the higher the percentage of 5 year cures. The more undifferentiated the tumor (i. e., osteolytic osteogenic sarcoma), the lower is the percentage of 5 year cures.

(4) The scope of radium and x-ray therapy in treatment of bone tumors is still to be accurately delineated.

RADIOTHERAPY OF THYROTOXICOSIS

Ernst A. May, M.D.,
Newark, N. J.

There is a well-justified tendency to consider certain conditions of the hyperactive thyroid gland, such as hyperthyroidism, toxic adenoma, toxic goiter and exophthalmic goiter (also called Basedow's or Graves' disease), as different manifestations of a single disease. Whether this hyperfunction has its stimulus within the thyroid gland itself, or whether it is a reaction to a stimulus from without, is not yet quite clear. The entire modern surgical method of removal of a part of the gland is based on the thyrogenic theory of Moebius, who considers the thyroid gland as originally diseased. On the other hand, Moschcowitz comes to the conclusion that the changes in the thyroid gland are the result of disorders of other parts of the body. Marine finds that hyperthyroidism is due to suprarenal and genital dysfunction. Together with the symptoms of the thyroid, he finds hyperplasia of the lymphoblastic tissue, such as spleen, thymus and regional lymph nodes, and an atrophic condition of the suprarenal cortex. Bircher produced Graves' disease in dogs by implanting thymus tissue from patients suffering from that disease.

It is quite natural that medical men should try, especially in the less severe case, to influence thyrotoxicosis with conservative measures. They have often succeeded in keeping the condition under control, but seldom has a real cure been effected in a severe case. The treatment of hyperthyroidism has thus gradually changed from the medical to the surgical.

There are few conditions requiring more skillful surgical handling than toxic goiter. The statistics of surgeons who specialize in goiter operations show 70 to 80% cures. The primary mortality is from 1 to 10%; there are 20 to 30% of recurrences; and symptoms of myxedema can still be found in 1 to 5%. The figure for cures falls off rapidly in the statistics of surgeons who may be highly skilled in other fields, but who do not perform many thyroid operations, and their mortality rate rises, in many instances, far above 10%, as Thompson *et al* have demonstrated.

The surgical result depends upon the amount of thyroid tissue removed; as the plan requires that enough be taken to check the disease but enough left to avoid myxedema. The preoperative iodine treatment of Plummer has greatly facilitated proper preparation for surgery and reduced the primary danger of the operation. The initial beneficial action of the iodine on the patient has its optimum at the

end of 2 weeks. Its continuation has, in many cases, proved to be more harmful than helpful; a fact not well recognized by a large number of physicians who administer iodine over a long period of time.

In the past few years, more and more reports have appeared on radiotherapy in this disease. The results are so encouraging that in Europe it has, in many instances, superceded the other 2 methods. Radiotherapy in this field was originated 30 years ago in this country by Williams, one of the pioneers in the use of x-rays. At the last convention of the Radiologic Society of North America, in a symposium on thyroid disease, Menville presented a paper built upon a questionnaire he had sent out, reporting 10,541 patients, from all parts of the country, who had received radiotherapy. Of those, 67% were cured and 21% showed marked improvement. There were only 12% of failures, which included 8% recurrences. Of all these patients, about 10% were treated for recurrence following surgery. The mortality can be rated at less than 1%. This questionnaire reports on results obtained by an unselected number of radiologists using different methods. If compared with the statistics of an unselected number of surgeons, the comparison is obviously favorable. If one tries to establish the value of one method of treatment as compared to another, it is quite natural to work with extremes. Once the value of the new method has been proved, its real benefit in management of the disease will best be seen by using good judgment in the selection of patients and combination of methods. No one method is a cure for all, each having its advantages and disadvantages for the individual. It is, therefore, timely to give radiotherapy its proper place in the treatment of thyroid disease beside internal medicine and surgery.

In speaking of radiotherapy, I refer to the application of radium or high voltage x-rays. Animal experiments have proved that the normal thyroid gland is little, or not at all, sensitive to radiation. In the treatment of carcinoma of the thyroid or larynx, the thyroid gland receives very heavy doses of radiation, but no myxedema has ever been described. The hyperactive thyroid gland becomes increasingly sensitive to radiation, perhaps owing to the increased amount of lymphoid tissue within the gland. In trying to inhibit over-function, both surgery and radiotherapy strive for the same end. Surgery reduces the size of the gland to a minimum, leaving an amount of the still over-active thyroid tissue sufficiently strong to produce the thyrin necessary for the body to avoid myxedema, and small enough to inhibit persistence of the hyperfunction. This requires extreme skill and judgment. The recurrences after operation are in reality more or less persisting hyperthyroidisms, as Thompson and others have shown with the material in the Massachusetts General Hospital. Only a few true recurrences could be found. Radiotherapy has not the spectacular result that surgery produces. After an operation the basal metabolic rate drops and the goiter has disappeared. Under radiotherapy the improvement of the patient is more gradual. Soon after the second or third week, a reduction in the pulse rate, a drop in the metabolic rate, and a decrease of the nervousness are evident. The patient gains weight and feels stronger; he is soon able to resume his work. Hospitalization need not be resorted to except in the extreme case. Mortality has been reported in only the most severe cases, which were far beyond operability and in which radiotherapy had been tried as a last resort. Death would have occurred to those patients at about the same time, with or without the administration of the x-rays. A small or moderately sized goiter will shrink gradually under treatment, and will finally disappear. Exophthalmos will respond only slowly, and in a manner similar to that after operation.

In a large toxic goiter the symptoms of tachycardia and tremor may improve or even disappear, and the basal rate may return, together with the body weight, to normal, but little shrinkage may be expected in the size of the goiter. Such patients belong to the surgeon, especially as they do not consider themselves cured so long as any enlargement of the neck persists, even though freed from hyperthyroidism. But, with such patients the surgeon can avail himself of the advantages in combining the 2 methods. A pre-operative

series of treatments, in toxic goiter, will tend to cause the risk to approach that of a simple goiter. It has been said that previous radiation produces adhesions of the capsule and more bleeding, thus making the operation more difficult, but, as has been stated by prominent surgeons, this condition is due to previous thyroiditis and not to the treatments, and is found in non-radiated patients in the same ratio. This procedure has been followed in 6 patients with the result that all 6 are in good condition today; 3 were sent for radiation because they were too poor a surgical risk. After a series of treatments the basal metabolic rate decreased and the heart gained in strength, thus making the operation possible. Two others were also much benefited by the radiation and had an uneventful recovery from the operation. One case of a huge goiter with symptoms of toxicity, in a woman over 60 years of age, did not show much response to the treatments, but the operation was a complete success.

Surgery is also indicated when quick action is required. If there exists an impression that the worn-out heart is not able to bear up under the strain of an over-active thyroid gland, improvement may be expected sooner after a quick subtotal thyroidectomy. Advanced age of the patient should cause one to incline more to surgery than to radiotherapy. The 3 failures I have to report occurred in patients over 60 years of age. The other 7 patients who were above 60 were cured. But it seems to be true that the susceptibility of the thyroid tissue to radiation in elderly persons with hyperthyroidism is lessened.

Radiotherapy is indicated whenever complications from other organs render the patient a poor surgical risk. It is also better suited as treatment where there is lymphatic hyperplasia of spleen, lymph glands or thymus, because treatment of those organs, as well as the thyroid gland, is possible, thereby approaching a rational treatment in the theory of Marine and Moschcowitz. This enlargement of the lymphoid system has been found, it is well to remember, in a large number of cases of Graves' disease.

I do not believe that economic reasons should lead a patient to prefer an operation to x-ray or radium treatment, because in the majority of instances he will be able to go to work again sooner under radiotherapy than after an operation. Last, but not least, the ability of the physician must be taken into consideration; an experienced surgeon will always obtain better results than a radiotherapist who lacks experience in this particular field, and *vice versa*.

Before undertaking any kind of treatment, the patient must be thoroughly studied to determine the type of thyrotoxicosis, and whether or not other organs are involved. The fact that almost 90% of thyroid patients are women, suggests very strongly that there is a close relation between thyroid and ovary. In many women the thyroid trouble becomes apparent in the adolescent or climacteric period. Shock and fright are also responsible for the beginning of thyrotoxicosis. The further the affection advances, the more the heart suffers. In order to obtain good results, all these symptoms should be taken into consideration, and the necessary steps in medical treatment taken. A basal metabolic rate is essential, and should be taken at regular intervals. The patient's weight is almost as good an indicator. The more the over-stimulated function of the body recedes under x-ray treatment, the more easily can the system assimilate nourishment. Gains of 20 to 30 lb. are not uncommon, and any decrease of weight during treatment suggests a complication of disturbances other than those of thyrogenic origin. The effect of radiation on hyperthyroidism is so certain that this statement may be made definitely. Tachycardia is another symptom seen to improve early in the course of treatment. If one considers that those patients who have a pulse rate above 150 have to stay in bed 4 or more weeks in order to become a lessened surgical risk for the pending operation, one can see a distinct advantage in radiotherapy over surgery, as the patients, after 4 weeks of x-ray treatments, are so much improved that they are able to resume their work. It is not necessary, as a rule, even in severe cases, for the patients to be confined to bed or hospitalized while taking treatments. However, such procedure is indicated in cases

of severe emaciation or heart complication. The continual use of iodine is not advantageous and should be discontinued. In several of my patients the family physician has insisted upon continuation of iodine and I have gained the impression that progress was not so satisfactory as with those who did not receive iodine over long periods. But mild heart stimulants, iron arsenite medication, and a diet rich in proteins have proved helpful, and mild sedatives and hypnotics as well, should they be indicated.

Postoperative recurrences, which amount to about 25%, are a very good field for radiotherapy. Of 14 surgical recurrence patients I have treated, 1 died, 2 were much improved and 11 were cured. The patient who died had been subjected to a ligation of the thyroid arteries. She was too poor a surgical risk for thyroidectomy, and died of heart failure 6 weeks after the last x-ray treatment. Ligation, in itself, is not a curative procedure. It can be considered as preparation for a radical operation, which must follow very soon afterward, and before the blood supply through collaterals has been regenerated. The result accomplished by ligation, however, can be more easily and safely gained by pre-operative x-ray treatment. Patients whose basal rate, toward the end of the treatment, has reached a figure slightly below zero, will do best. The rate will rise again after a short time and remain about zero. The same may be said in regard to changes in weight. The patients must not be too concerned about gaining too much weight, as they will lose the excess in a manner similar to that of the basal rate.

I have never seen myxedema produced by radiotherapy. It could be caused only by a dose which would be many times that usually given. The cases of myxedema previously reported may have occurred in the early years of experimentation, and could not be justified today.

A patient was referred to me for treatment of a carcinoma in the floor of the mouth with involvement of the cervical lymph glands, and complicated by a toxic goiter. A section from the mouth tumor revealed epidermoid carcinoma. This disappeared under intensive radium and x-ray treatment. Simultaneously, the symptoms of toxic goiter disappeared entirely, and the basal rate is around zero. This patient received through the thyroid gland 4 to 5 times the average dose given to a goiter patient, but no myxedema is present, and there has been no recurrence either of goiter or carcinoma after more than 2 years.

The radiation treatment must be guided by the symptoms of the individual. The more severe, the smaller the dose given. To test out the reaction, the initial treatment may be given only over a small portion of one lobe, especially in a severe case. I have never seen a directly stimulating effect of the x-ray treatment on thyroid tissue. The excitement caused by the visiting radiologist, and apprehension concerning a treatment strange to the patient, may be additional strains on the already over-burdened heart, and should be overcome by a dose of bromide or other sedative. I have come to the conclusion that large doses of x-rays such as half an erythema dose, or more, at one time, are too much for many patients. According to the severity of the case, I give from 3 to 10% over one lobe at a time, giving the treatments twice a week, later once a week, until a series of 10 to 12 small treatments are finished. Usually the x-rays can be applied from the left and right sides, by a field sufficiently large to guarantee enough radiation in the middle lobe, even if this is much enlarged. To give an additional field over this middle lobe from the front is a mistake, as it produces an overdose to the middle lobe and endangers the larynx. If the dosage is given properly, only a slight reactive laryngitis will occasionally occur. There is no danger of necrosis of the cartilage. A field over the thymus and, if indicated, over the spleen, is always included. This careful and moderate dosage will insure best results, in my experience. I have never had to regret any effects produced by too much radiation. One must also bear in mind that the skin of the thyroid patient is more susceptible to radiation than the average. Changes in the skin, such as telangiectasis, are avoidable, and are only excusable in the stubborn case. If one wishes to avoid all untoward effects, and pos-

sible lawsuits, high voltage radiation of at least 150 kilovolts and 0.5 mm. copper plus 3 mm. aluminum filter should be used, rather than low voltage with aluminum filter, as it secures much better penetration and more homogeneous distribution of the rays through the neck. The application of radium is done from different portals of entry through a mols fitted around the neck of the patient. It is left in place for 500 to 1000 milligram hours at 2 cm. distance between radium and skin. The radium is filtered through at least 1 mm. of brass.

Between 1923 and 1932, 160 patients have finished radiation treatments for the different forms of hyperthyroidism, either at my private institution or at the Metcalf Foundation, in Orange. Of these, 132 (82.5%) were cured; 25 (15.6%) were much improved; and 3 (1.9%) showed little or no improvement. In 6 cases of large toxic goiter, radiotherapy showed an improvement in 5 and 1 failure. All were cured by an operation following our treatments. This number is, of course, too small to draw any conclusions but it helps to emphasize the value of the combined method. Of the group, 3 had been denied surgery; but operation became possible after a series of treatments. If regarded as to total end-results, the statistics of these 160 treated with the combined methods would show 138 (86.25%) cured; 20 (12.5%) much improved; and 2 (1.25%) unimproved. The total of cured and much improved amounts, therefore, to 158 (98.8%). As cures, I consider all whose basal rate has been reduced to a point between plus and minus 10, whose weight corresponds to that of the average; whose pulse has returned to normal; and whose tremor and palpitation, goiter and exophthalmos have disappeared. As improved, I have registered all in whom one of the above symptoms remains, as for instance exophthalmos, but all the others have disappeared. The remainder are registered as failures. There were 142 female and 18 male patients. Exophthalmos was present in 77. In all of the patients I have seen only 1 true recurrence, 3 years after the initial treatment series, and a second series cured that patient of the recurrence.

When looking over these statistics one gains the impression that the longer the time after the last treatment, the more favorable will be the result. It takes a long time for an exophthalmos to disappear. When the basal rate has remained steadily around normal for 3 to 4 months after the last treatment, the treatments are discontinued altogether, as whatever symptoms are then remaining will improve without further radiation. As time passes, a number of the patients now registered as improved may be listed as cured. The patients are allowed more freedom than after an operation, as their chance for a recurrence is very slight.

Summary

Radiotherapy in the different types of hyperthyroidism is of distinct value and should be recognized as one of the most powerful remedies for such conditions.

In plain hyperthyroidism and small toxic goiters it is superior to other methods, and is, therefore, the method of choice. It is also indicated in cases of poor surgical risk.

The mortality is less than 1% and recurrences are fewer than with surgery.

In large toxic goiter, in acute cases with impending heart failure, and in persons over 60 years of age, we should resort to surgery.

A pre-operative series of x-ray treatments will lessen the surgical risk and prepare the patient for thyroidectomy better than ligation of the blood vessels. It is suggested in all cases in which surgery is given preference. Previous radiation does not render the operation more difficult.

Recurrences after operation respond well to radiotherapy.

Of 160 patients treated with radiotherapy alone, 132 (82.2%) were cured; 25 (15.6%) were much improved; and, 3 (1.9%) were unimproved. Of these, 6 patients included—5 as improved and 1 unimproved—with large toxic goiters, were later operated on and are now cured.

Therefore, the results of the combined method are: 138 patients (86.25%) are cured; 20 (12.5%) were much improved; and 2 (1.25%) remained unimproved.

DISCUSSION

Dr. Milton Friedman (Newark): My results in the treatment of hyperthyroidism with radium and x-rays have not been so favorable as those of Dr. May, and correspond more or less with the results of most of the series being reported lately; to wit, about 70% cures. Furthermore, I find a higher percentage of recurrences than the 1% in Dr. May's series. My doses are heavier than Dr. May's and the treatment more intense. This should effect a more fortuitous outcome but, inexplicably, does not.

In spite of continued improvements in the technic and results in the treatment of thyrotoxicosis, radiotherapy has received little attention from surgeons and internists. This is due to a wide variation in technic and results, and an insufficient rigid standard of indications. If the radiologists could unite upon a definite routine program for handling all cases of hyperthyroidism, they would receive more frequent consideration from the surgeon.

I have attempted to employ, purely arbitrarily, the following plan for a therapeutic test, which appears to be functioning acceptably: A trial period of 1 month is designated for radiation; 3 treatments are given at 2 week intervals; each treatment consists of the administration of 3 40%-50% doses over the left, middle and right thyroid areas; 2 weeks after the final treatment a decision is made as to the advisability of continuing radiation or resorting immediately to surgery. If the response has been mild, suggesting that the patient will need long-continued treatment over a period of months, which will entail an economic loss to the patient owing to chronic debility, surgery is preferable. In this event, the patient has lost only a little money, but has been rendered more favorably operable from the slight benefit he has obtained. If the response at the end of the trial period is such that the clinically experienced eye and mind of the radiologist can prognosticate a cure, then therapy can be continued. It is important for the radiologist to remember that a thyroidectomy in the hands of a skillful surgeon is not a difficult operation and restores the patient to health in a short time, whereas radiotherapy of a slowly-responding toxic goiter is a prolonged procedure entailing semi-morbidity for a long time. By abnegating the latter type of patient, the radiotherapist will do more to win consideration of his medium than repeated reports of high percentages of cures.

Dr. J. Thompson Stevens (Montclair): I think that those of us who are here this afternoon have been very fortunate in hearing this presentation by Dr. May. As some of you may know, I have been interested in this subject for about 16 years and in that time I have treated a large number of patients for toxic goiter, hyperthyroidism and toxic adenoma.

Last year, at the American Medical Association meeting in Philadelphia, it was my privilege to report on some 325 patients whose treatment had been completed at least 1 year previously. As Dr. Friedman has just said, there is quite a controversy going on between the surgeon and the radiotherapist as to whether these patients should have surgical or radiologic treatment. I think we must confine our treatments to the purely toxic types. You can't get a result on a non-toxic type with such radiation as we are talking about today.

I recognize 3 types of thyroid disease for treatment by irradiation. (1) The one characterized by a tumor at the site of the thyroid gland which you can see upon direct inspection or which you can demonstrate by an x-ray examination of the chest in the upper mediastinum: such condition as we call toxic goiter. (2) The patient with tremor, rapid pulse, loss of weight, nausea and vomiting, diarrhea, and an elevated metabolic rate, without enlargement of the thyroid gland visible by direct inspection or demonstrable by x-ray examination; which I call hyperthyroidism. (3) Then, there are the nodular thyroids and in the presence of toxicity, I know them as toxic adenomas.

The surgeon raises the question at the present time, in particular reference to the toxic adenoma, as to the possibility of their later becoming malignant. Therefore, they say we should not treat these patients by radiation. Dr. Pfahler presented a paper not long ago before some medical society in Harlem and wrote to me, among others, before he presented the paper, asking how many cases of carcinoma I had observed in this period of 16 years following radiation of toxic adenomas. I and about 8 or 9 others were able to report 1044 cases, I think, and there wasn't one of them, so far as any of us were able to determine, that had ever developed a malignancy.

For hyperthyroidism and toxic goiter, I personally believe there is no better treatment than x-radiation. The symptoms of the disease, the tachycardia, the tremor and gastro-intestinal symptoms will disappear, and the metabolic rate will return to normal.

In the toxic adenomas, I believe that in the majority of cases the best x-radiation will not accomplish satisfactory results, but I have observed a number of times that the implantation of radium element needles around the mass, and into it, will produce remarkable results. Generally one treatment is sufficient to remove the tumor, to produce normal basal metabolic rate, and to cause all of the symptoms of the disease to disappear.

There is a question about infection, too, that enters into the argument. Some men will tell you that you cannot get a result in toxic goiter or hyperthyroidism without hunting up some source of infection and giving it irradiation. This, I have found to be true in some cases. But in fastidious patients, for instance, with abscessed teeth in the front of the mouth which they refuse to have removed, we haven't had any very great difficulty in getting the result without eradicating that abscess. For that reason, I am unable to state exactly what rôle infection may have upon the controllability of this disease.

Chairman Herrman: When I urged on the Trustees of the State Society the advisability of having a Section on Radiology, it was with the hope that we would get before many of the general men, many of the surgeons, some of the work that we are doing. As Dr. Stevens said when we opened the meeting, we are more or less talking to ourselves this afternoon. That seems to be the general situation when we try to give papers on radiotherapy. I feel that so far as the State Society is concerned, we have to do 1 of 2 things next year; each of us has to bring 2 clinicians with him to the meetings or else we must try to get some of this work in the General Sessions, because I believe that some of the opposition to radiotherapy (for instance, in the condition under discussion) is due to lack of knowledge on the part of the general medical men of what we really can do. When I say "we", I mean men experienced in the use of radiotherapy. I haven't figured up my own records to give you any percentage, but I feel about this subject much as Dr. May and Dr. Stevens have expressed themselves—that we get a very high percentage of good results.

I am quite in accord with Dr. May as to the size of the dose and have often wondered if perhaps less favorable results some men were reporting were not due to their dosage. It is my custom to give anywhere from 10 to 20% at one sitting and not treat them again for 2 weeks.

So far as spectacular results are concerned—I have seen some in young women, when they came very early after onset of the hyperthyroidism; 2 come to mind very quickly—who in 6 weeks' time returned completely to normal with 3 treatments. I think some of you will remember the symposium which the radiologists had in Cleveland several years ago. That meeting summed up the situation very well. The radiologists were broad-minded enough to have some of the leading opponents of radiotherapy appear on the program. So, Drs. Mayo, Crile, and Lahey appeared on that program, and after they had expressed themselves very frankly and very fully, Dr. Christie, of Washington, threw a lot of case records on the screen, records of patients he had treated subsequent to operations, and every one had been operated upon by men just named.

Dr. Mayo closed the session. You know he is the "prince of diplomats". He said: "Gentlemen, I think this evening has proved that we are all talking at cross purposes, because when we surgeons deride radiotherapy, we are thinking of the failures of radiotherapy that come to us for treatment, and we must remember the radiotherapist is treating our failures which we may have included among our favorable results."

There is a field for both methods of treatment. There is a field for a combination of them. I do not feel that radiotherapy is sufficiently well recognized by the medical profession at large for what it may accomplish in the treatment of this condition. Somehow, in some way, we must get the knowledge before a larger audience.

Is there any further discussion? If not, Dr. May, will you close?

Dr. Ernst A. May (closing discussion): Thank you very much for the discussion.

Dr. Friedman is complaining that his results are not so favorable as those of my statistics. I think you will eventually show improvement in your records, because as time goes on, the cases you may register now are only improved, will show a final cure. It takes time for a hyperthyroidism, especially toxic adenoma and exophthalmic goiter, to disappear.

I remember very well, a case which I started to treat in 1924, a young woman with extreme exophthalmic goiter. I registered her first as a failure, but later on she improved so much, that when she stepped into my office 3 years later, I did not recognize her. The exophthalmos was all gone, the basal rate was normal. She had married and had 2 children. This fact seems a good proof. Pregnancy is such a great strain on these cases, that if they go through a normal pregnancy without recurrence of hyperthyroidism, you may consider them to be in very good condition.

I only hope the situation will be cleared up a bit more so that we can better recognize the lines of indication toward radiotherapy in the treatment of the hyperthyroid case and the small toxic adenoma. The large toxic adenoma should be operated, perhaps after an initial x-ray treatment or series of treatments.

Give them time. I don't think it is right to wait only 2, 3 or 4 weeks for the case to show results. Sometimes it takes longer. As soon as the weight starts to go up, then they are favorable and it is an indication that they will respond. I think we can even go so far as to say that radiotherapy, in the cases which I have mentioned, will do better than any of the other methods.

CEREBRAL HEMORRHAGE OF THE NEW-BORN

Lewis Robbin, M.D.,
Newark, N. J.

Approximately 10% of all infants suffer, in varying degree, from intracranial hemorrhage. One investigator states that 10% of all deaths during the first month of life are due to cerebral injury. That cerebral hemorrhage does not become, as Hunekins has stated, "a most neglected phase in the care of infants", a brief survey of some of the important aspects of the condition might not be amiss.

Etiologically, intracranial hemorrhage may be attributed, first, to the trauma incident to birth, and, secondly, to a bleeding diathesis of the new-born. Congenital infection, especially syphilis, friability of the blood vessels, and malformation, play a surprisingly unimportant rôle in the causation of cerebral hemorrhage. The predisposition to bleed has been found in as high as 50% of instances. Toxemia in the mother and fetus has some effect, no doubt, on the friability of the fetal blood vessels. Trauma, in contrast, is perhaps the most important causative factor.

For clinical purposes, the hemorrhage has been conveniently described as epidural, subdural, subarachnoid, intracerebral, and ventricular. Since the dura of infants is closely adherent to the skull, epidural hemorrhage is not common. Some authorities believe it never occurs. Subdural hemorrhage is most common. Subarachnoid extravasations may be either supra- or infra- tentorial. When above the tentorium, lesions of the falx, of its surrounding sinuses, and of the superior fibers of the tentorium cerebelli, may result. They are usually unilateral and offer the best outlook. When below the tentorium, lesions may occur of the tentorium cerebelli, sinus transversus, cerebellum, medulla oblongata, and the spinal cord. Thus, subarachnoid infratentorial hemorrhage

is quite often fatal and offers the least hopeful prognosis.

Symptomatically, the condition is suspected: (1) from evidences of irritation of nerve structures, causing excitement; and (2) from evidences of exhaustion, as a natural consequence of prolonged irritation of intracerebral destruction. Symptoms of irritation are various, depending upon the degree and location of the hemorrhage, as well as upon increase of intracerebral pressure. They commonly include convulsions, localized or general; evidences of pain in the characteristic cry and facial expression; opisthotonos; muscular rigidities; cyanosis; and irregular breathing. Exhaustion manifests itself in pallor or in blueness of the skin; mild or deep stupor; or, merely through inability to nurse. Of the symptoms most noticed in the acutely affected patients whom I have seen in the past decade, convulsions associated with cyanosis, or, rigidity and cyanosis, on the one hand; and inability to nurse, associated with a state of shock of varying severity, on the other; stand out most clearly in my mind. Bulging of the fontanelle is absent, as a physical sign, in all infratentorial hemorrhages.

In contrast to these indicative symptoms, it is important to note that the condition is often asymptomatic. This may be true as to large as well as to a slight hemorrhage. Outpouring of blood in regions away from motor centers may be without tell-tale force. Routine lumbar puncture in a large series of apparently normal infants, by various investigators, has established this finding.

Evidence of hemorrhage may occur within the first 24 hours and, as a result of blood clotting insufficiency, as late as the tenth day.

The spinal fluid, after successful puncture (a feat not without its difficulties), shows red blood cells in varying degree, xanthochromia, and increased pressure, the normal pressure being about 4-6 mm. mercury. Each of these findings has, in itself, been disputed as a prima facie evidence of hemorrhage. Red blood cells have been attributed to accident incident to puncture. Normal clotting and bleeding times have been observed in the presence of bloody fluid. Blood-stained spinal fluids have been, in some instances, unsubstantiated by later autopsy. When cerebral edema alone has been observed, xanthochromia has been regarded rather as an evidence of widespread destruction of over-produced blood by the fetus. This is easily understood when one remembers that all tissues within the fetus are hematopoietic. Increase in pressure is itself unreliable. Straining by the infant, resistant to the hyperflexing by the assistant in properly holding it, is sufficient to raise the pressure 10 times the normal.

In attempting a diagnosis, one must especially rule out: pulmonary atalectasis; sepsis of the new-born, especially pneumonia and peritonitis, rarely meningitis and encephalitis; and edema of the brain. For instance, in an infant delivered by Dr. Frederick Lovell, exhaustion developed on the third and death occurred on the fifth day. Clinically, the picture was typical of cerebral hemorrhage of the exhaustive type. Autopsy revealed only consolidation of the bases of both lungs. Significantly, perhaps, the spinal fluid of that infant was clear. Atelectasis, however, may itself often be a result of intracranial hemorrhage.

The prognosis varies, according to various authorities. Some hold that such infants are never completely cured. Others maintain a more optimistic view. Much, of course, depends on the extent of the extravasation, its location, and the vigor of the infant. If, as some authorities maintain, some degree of hemorrhage occurs in all births, complete spontaneous cure is often an inevitable following. The supracortical vessels, sinuses, and pacchionian bodies absorb the blood completely. Even symptomatic hemorrhages may be spontaneously cured. However, a large number of infants either somewhat mentally backward, or slow in power to gain in weight and in growth; or presenting various bizarre movements of the extremities, such as continually rotating the wrists and moving the fingers; or evidencing a so-called state of hypertonicity; or giving the picture of so-named colic with its attendant digestive disturbance and almost continuous crying and fretting—this large number of familiar conditions lends support to the statement by Schwartz, of Berlin, that the pathology of the first month of life is completely dominated by birth injuries of the

brain. Certainly, injury to the dura is sufficient to explain many of the instances of the ceaseless nerve-racking crying of small infants.

Graver consequences, such as imbecility, idiocy, spastic diplegia (Little's Disease), hemiplegia, and epilepsy are too well known to require description.

Treatment of intracranial hemorrhage is as controversial a subject as is the diagnosis. Grulee is extremely pessimistic, holding that no treatment is of any avail. In a measure, he is supported by Herman Schwartz, of New York. They hold, among other things, that no one person has seen a sufficient number of cases to evaluate results. In some instances, when lumbar puncture is done, blood is found and the child gets well; in others the child does not get well. Grulee emphasizes the statement that in bending the infant, in the process of puncture, one increases venous congestion and the tendency to hemorrhage. That procedure is, therefore, not without danger. Furthermore, he states that since the brain of the new-born is jelly-like, hemorrhage into this soft material is destructive. He holds it is impossible to tell whether we are not dealing with primary defective brains rather than brains affected by hemorrhage. If there is destruction, the power of recuperation is in the glia alone, not in the nervous tissue; therefore, treatment is useless. Wilson, Foote, Hunekins, Sharpe, and a host of others have not taken so hopeless a view. Spinal puncture daily for 5 or 6 days, sufficient usually to clear the fluid, is the method of choice. Many infants soon lose all evidence of cerebral involvement and thrive as normal. Others are definitely, although not completely, improved. I have no experience with trephining or craniotomy, with incision of the dura and the evacuation of the clot (Cushing's operation); but if by the fourth day improvement is not evidenced and localization of the clot is possible as subdural supra-arachnoid, the operation is conceded by many as indicated, but the mortality rate is high.

Puncture, associated with transfusion or the intramuscular injection of whole blood, has been my only measure of treatment. Empiricism has been my guiding principle rather than theory. One cannot be but impressed by the marked and rapid immediate improvement of many such patients after employing these measures.

Yet, it must be admitted, that the future of even some of these apparently cured infants is in doubt. Epilepsy and mental disturbance in after years do appear in many instances as an inevitable consequence.

Prevention is, therefore, unquestionably the best method of reducing the incidence of cerebral hemorrhage of the new-born. The problem belongs essentially in the field of obstetrics. Huga Ehrenfast emphasizes the avoidance of haste in delivery. Every possible means of avoiding difficult labor should be taken. Prematurity, bleeding tendency, and biologic inferiority, are more difficult factors to cope with. Still, much can be done if irritability, apathy, or cyanosis in the new-born be recognized as evidence of intracranial hemorrhage.

RADIOGRAPHIC TECHNIC

Charles Frederick Baker, M.D.,
Newark, N. J.

My reason for writing a paper on this subject is to pass along for the use of the average roentgenologist a system which has enabled us to consistently reproduce the same type of work. I am frequently called upon to review the work of others and realize that more careful study of technical procedures would be a help in many laboratories. Many charts of exposures are published in book form or otherwise. We feel it is much better to have a card index, showing at a glance the exposure which has been found ideal for a certain class of work, the details of which have passed from the mind. Such a record of exposures renders duplication of results possible and the employment of a new technician an event no longer to be dreaded, for he or she will soon be turning out the same quality of work.

(1) What constitutes a good roentgenogram? I would say detail, contrast, and clarity, all of which tend to brilliancy.

(2) What methods are essential in pro-

ducing these qualities? They are: (a) perfect photographic technic; (b) the use of known voltages; (c) proper timing; (d) measurement of the part; (e) record of ideal previous exposure.

Detail is best obtained in bone work by use of a fine focus-tube and omission of the intensifying screens when possible. No matter how perfect the intensifying screen, nor how good the contrast, detail cannot be as good as when plain film is used. In examinations of extremities, therefore, it is always well to avoid, if possible, the use of screens. The use of the Bucky diaphragm requires the film to be an inch or more from the nearest bone, which diminishes sharpness of definition and its use is to be avoided in extremity work except when shoulders or thighs are very heavy. There is a tendency on the part of some radiologists to use the Bucky diaphragm in skull work, but roentgenograms so made, while brilliant, artistically, are not as satisfactory to interpret as those made otherwise. The use of screens in examining skulls is imperative on account of the long exposures necessary without them.

When studying the minute detail of a vertebra one frequently wishes for better local detail than is obtainable in roentgenograms made with the Bucky diaphragm. We find satisfactory pictures can be made of this region by the fastest screen with approximately 60 KV. 30 ma. using the 10 ma. radiator Coolidge tube at 24 in. distance, and a cone to cut out secondary rays. Exposures of 2 or more seconds are required, depending upon the density of the subject.

The detail of the gall-bladder is also satisfactorily demonstrated in this manner, a patient measuring 7 in. in anteroposterior dimension of the abdomen, requiring an exposure of 3/8 second at 60 KV, or less, 30 ma. fine focus tube, 24 in. distance.



Fig. 1. Demonstrating progressive loss in density when voltage is raised in 10 K. V. steps, other factors remaining constant excepting the time, which was halved and quartered respectively.

One of the chief advantages of the newer high powered machines is that they will permit the use of much lower voltages, greater milliamperage, and corresponding reduction in time, thereby increasing contrast between bone and soft tissue. This will eventually make it possible to dispense with the Bucky diaphragm in examinations of the gall-bladder.

If short focal distances are to be used, up

to 24 in., the fine focus 10 ma. tube gives sharper detail. The 30 ma. tube which has a broader focal spot requires the use of greater distance, prolonging the exposure and even then the detail is not as good. Not all realize that the tubes of finer focus can be used at higher than normal rating provided the limits set by the manufacturer are not exceeded. A chart showing these ratings is now supplied by the manufacturer on request. For example, the Coolidge 30 ma. tube can be used for 1/10 second at 100 ma. with voltages up to 100 KVP, and the 10 ma. tube can be used at 30 ma., 85 KVP for ½ second.

Contrast is obtained by keeping penetration or voltage to the minimum requirement of the case. Failure to realize this is one of the principal reasons for unsatisfactory quality. When too low a voltage is used the result will be unsatisfactory because the parts will not be penetrated sufficiently to bring out detail. When the voltage is too great the resulting roentgenogram has a gray color and lacks contrast. Some of this is due to the fact that the part under examination is not sufficiently opaque to absorb more than a small proportion of the rays, some to back-scattering or to secondary radiation set up in the tissues. Theoretically, therefore, it would be to our advantage to search for the critical point to which the voltage may be increased and the time diminished so that the secondary and back-scattering rays shall be reduced to the minimum, thus producing the least possible deleterious effects without using the Bucky diaphragm. This can be done satisfactorily with low capacity, fine focus tubes in the examination of extremities, the skull, sinuses, and cervicordorsal spine. It becomes a greater problem with the lumbar spine and pelvis owing to increase in surrounding soft parts. Low voltages with extremely great milliamperages up to 1000 or 2000 ma. are possible with the newer single and 3-phase machines, but without such equipment we are obliged to manipulate our exposure to this critical point where one might be reasonably satisfied with the result. If, however, the patient is very stout, we are compelled to employ the Bucky diaphragm. Use of the cone was the earliest method to improve contrast and its use is still highly recommended.



Fig. 2. Demonstrating no change in density or contrast when voltage was raised in 15 K. V. steps, the time being halved and quartered.

In juggling the factors to obtain the best possible roentgenogram it has been said that raising the voltage 10 kilovolts permits halving the time. This may be true of one machine, while in another a greater increase in voltage is necessary. One of the slides demonstrates

that on a certain apparatus, increasing voltage by 10 kilovolt steps did not result in equal contrast and densities when the time was halved and quartered, there being a progressive loss of density.

Another illustration shows that increasing the voltage by 15 kilovolt steps resulted in equal densities, contrast, etc., at ½ and ¼ the time respectively. In the first, 70, 80 and 90 and is determined by the starting point. For instance, much greater intensity is derived by adding 15 kilovolts to 88 kilovolts than by increasing from 55 to 70.

Clarity can be obtained only by normal darkroom technic.

(1) In discussing methods essential to the production of good roentgenograms it would surprise you to learn how few roentgenologists



Fig. 3. Demonstrating how factors may be changed so as to reduce the time of exposure without appreciable change in result. See text.

KV were used and 4.8, 2.4, and 1.2 seconds respectively, all at 24 in. distance. In the latter, 75, 90, and 105 KV were employed with normal other factors halved and quartered as before, the time used was 2, 1, and ½ second. The increase in kilovolts which will enable one to cut the exposure in half is apparently not constant for every machine, so I think it must be determined for each. It also varies with

are interested in the photographic procedures. These are generally relegated to the technician who may or may not be supervised in this department. The prime essentials to the making of clear roentgenograms are: fresh solutions at proper temperature; time development and allowing film to remain in developer without examination till finished; and, proper rinsing before fixing. With some workers the de-

veloping and fixing baths are frequently used until depleted to such a degree that they cannot give good results. Every laboratory should keep careful record of the dates on which the solutions were newly made, and after the normal period of use they should be discarded. This normal period of use must be determined in each laboratory, varying with the volume of work. I have been consulted on more than one occasion as to the cause of poor results and always begin by investigating the darkroom, and I find, as a rule: that no one can recall the exact date on which the developer was made; the hypo is opalescent, indicating that it is of no value; and the temperature and time factors in development are ignored. Now, it is simply impossible to proceed further toward obtaining a scientific exposure technic if you will not devote yourself to these photographic matters, because, without precision in the darkroom, one cannot judge differences in other factors entering into the production of a satisfactory roentgenogram.

The temperature of the developer should be taken at frequent intervals until certainty exists that it is neither becoming hotter nor cooler. Careful rinsing of films, for 15 seconds or more in running water, before fixing, will save deterioration of hypo and prevent the film being stained by unused developer carried in the emulsion to the hypo tank.

The use of known voltages is only possible when a pre-reading volt meter becomes an integral part of your apparatus. The circuit should also include a large Coolidge ammeter with figures large enough to permit small variations to be easily read.

With these 2 instruments you may select your voltage and milliamperage at will and obviate the changing of your filament current during the exposure. When these instruments have been installed one may chart the peak kilovolt, determined by sphere gap as against the voltage as indicated on the pre-reading meter, and can then quickly and certainly select any voltage at will. It is well to calibrate for 10, 30, 60, 100 and 250 ma. or more if your machine is capable of a greater output. If you are unequal to this task call in your service man but be sure your calibration is accurate as you will expect to use it daily.

(3) It is perhaps unnecessary to recommend an accurate timer but without it unexplained errors will creep in. Any timer should be frequently checked for accuracy. The impulse timer for extremely rapid exposures is becoming an essential in well equipped laboratories and is supposed to be free from error. Its use is limited between 1/120 and 1/4 second.

(4) Measuring the thickness of the part is essential in all but roentgenograms of the extremities. The advantages will be stressed later in the consideration of examinations of the spine, kidneys, and gastro-intestinal tract.

SHOULDER

Tube	KV	PreR-Volts	Ma.	Distance	Time	Screens	Bucky
10 ma.	75	35	10	24 in.	10	0	0
10 ma.	90	45	10	24 in.	5	0	0
10 ma.	105	55	10	24 in.	2½	0	0
30 ma.	105	65	30	36 in.	1⅞	0	0
30 ma.	105	70	60	36 in.	.9	0	0
30 ma.	105	70	60	36 in.	.1	yes	0

Fig. 4. Type of index card used for shoulder technic.

(5) Supervision of the records of exposure can best be done by the roentgenologist. I find it very helpful to keep a card index system in which we record the most satisfactory method to us of making roentgenograms of every sort.

In the index we not only have records of so-called normal exposures, made with the cooperation of the patient, but in addition, proved exposures of the same part with exposure time much reduced for those who will not coöperate. For example, unless a patient has a very stout shoulder a plain film made without screens gives us the best roentgenograms. If there should be the possibility of movement the time may be reduced as illustrated in this article. The illustration shows the same shoulder taken with 10 seconds at 70 KVP, 10 ma. and 24-in. distance, in 5



Fig. 5B. Same knee—large cone—30-inch distance, no change in time or other factors.



Fig. 5A. Knee—made with small cone, 24-inch distance.

seconds at 75 KVP, 60 ma., 36-in. distance and 2½ seconds at 90 KVP, 60 ma. and 36-in. distance. .If necessary, screens must be used and we have found the speediest screens will cut the time to 1/10 the normal without screens. The index should therefore contain a card showing such an experiment. It is not to be inferred from this that the same results will be obtained on every type of apparatus but you are urged to keep such records of satisfactory work to help in reproducing roentgenograms of the same quality.

Regional technic. The long bones and their articulations, excepting the hips, may be well radiographed with a fine focus tube, medium cone, 10 ma. at 24 in. If it is desired to include entire shafts, the next larger cone may be used at 30 in. without changing the time and with no loss of contrast. The bones should not be so dark that the cortex and soft parts cannot be clearly differentiated, else slight pathologic changes of inflammatory or neoplastic origin may be missed.

Lateral views of the skull with 10 ma. tube at 36 in. are made in 2 seconds at 10 ma., or 1/3 the time at 30 ma. This distance gives fairly parallel rays without distortion. The views in the sagittal plane may be taken in the same time at 30 in. If the slower screens are employed, double the time will be required. The kilovoltage best suited is between 78 and 88 depending on the efficiency of the machine, the clearer roentgenograms resulting from a comparatively low voltage. The base of the skull is much neglected and should be examined routinely. It is best shown with the vertex resting on casette and rays passing through skull behind the mandibular symphysis. The opposite position with chin on casette is difficult in any patient unless the neck is long and flexible permitting hyperextension and it is impossible in one with a skull fracture.



Fig. 6. Lateral view of skull, made without use of Bucky Diaphragm.

Our index cards of the spine show only the exposures of the lumbar area which generally includes the sacro-iliac articulations. The patient's thickness at or above the iliac crest is measured in the dorsal decubitus. In working out a technic tests should be made at approximately 88 KV or less, 10 ma. tube passing only 10 ma. until the type of roentgenogram which seems most brilliant is ob-

SPINE—lumbar. Bucky

	a. p. views				Lateral view			
5 inch	80 KV	10 ma.	3½	sec.	92 Kv.	10 ma.	14	sec.
6 inch	80 KV	10 ma.	5	sec.	92 Kv.	10 ma.	16	sec.
7 inch	80 KV	10 ma.	5½	sec.	92 Kv.	10 ma.	18	sec.
8 inch	80 KV	10 ma.	6	sec.	92 Kv.	10 ma.	20	sec.
9 inch	86 KV	10 ma.	7	sec.	98 Kv.	10 ma.	22	sec.
10 inch	86 KV	10 ma.	8½	sec.	98 Kv.	10 ma.	24	sec.
11 inch	88 KV	10 ma.	9	sec.	100 Kv.	10 ma.	26	sec.

Fig. 7. Type of index card showing exposures for spine.



Fig. 8. Gall-bladder, made with use of Bucky Diaphragm.

tained. From the record of this experiment one can roughly estimate the time to be added for each additional inch in thickness. Allowance of 25 to 33% more time must be considered in examinations of ultra-muscular types, or less in those whose abdomen may measure as much but whose tissues are atrophic or flabby.

The lower dorsal spine is overshadowed by the heart and liver and approximately 1/3 more time must be given, or if you prefer it the voltage may be raised 15 KV instead.

The upper dorsal spine on account of the slight density of the pulmonary fields about it requires 1/3 less time than the lumbar region.

The lateral lumbar spine requires 4 to 5 times the exposure of the anteroposterior view, or the voltage may be raised 5 to 10 KV and twice the exposure time used.

In kidney examinations the density of the soft parts should permit differentiation of the kidneys, psoas muscles, and lower margin of



Fig. 9. Same pt. as Fig. 8, made without Bucky Diaphragm. This technic valuable in eliminating motion due to respiration or pulsation of arteries.

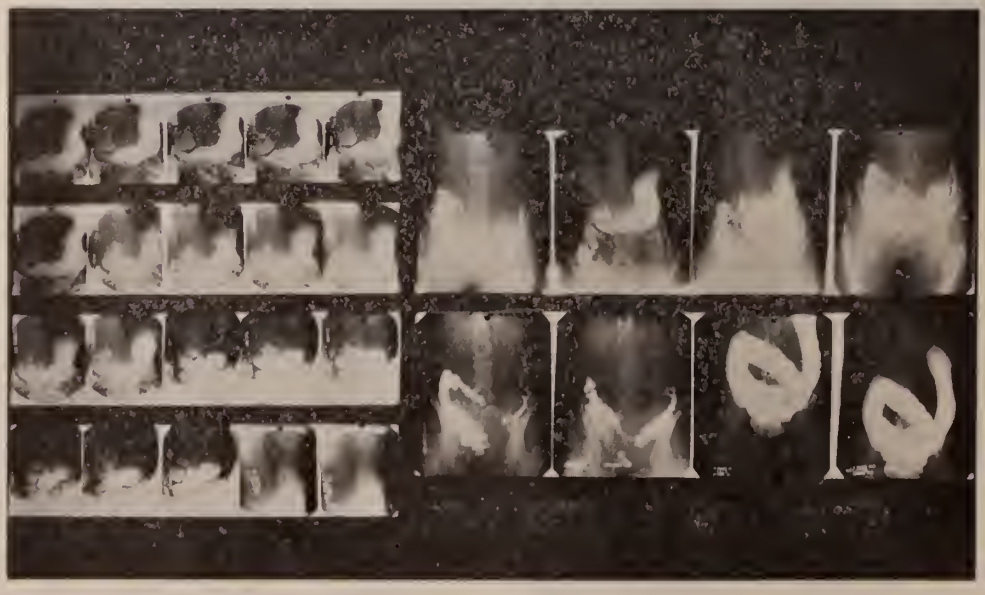


Fig. 10. View taken from viewing box of complete gastro-intestinal series, illustrating similar density in all films when method described in text is used.

G-I series. 8 in. pt.

Vertical	98 KV	60 ma.	3/10 sec.
Oblique	102 KV	60 ma.	3/10 sec.
Prone	92 KV	60 ma.	3/10 sec.
Oblique	102 KV	60 ma.	3/10 sec.
Supine	92 KV	60 ma.	3/10 sec.
½ hour	92 KV	60 ma.	3/10 sec.
2 hour	88 KV	60 ma.	3/10 sec.
30 hour	84 KV	60 ma.	3/10 sec.
48 hour	82 KV	60 ma.	3/10 sec.
Enema	88 KV	60 ma.	3/10 sec.

Fig. 11. Example of index card for gastric series in pt. with a. p. abdominal diameter of 8 inches, in upright posture.

the Bucky diaphragm but I would recommend that all try to develop a technic without it. This requires the use of the cone, about 50 KV 60 ma., and fractional parts of a second. By this method we have demonstrated better detail in the gall-bladder shadow and the presence of non-opaque stones which were not visible in the Bucky roentgenograms.

Gastric examinations require a fasting stomach prior to the barium meal, a much smaller



Fig. 12. Shows possibilities in spine technic with use of small cone and without Bucky diaphragm. Especially valuable in cases in which the time element must be considered.

liver. Detail is not so essential but shorter exposures are needed to obviate blurring through respiratory movements. We, therefore, employ a 30 ma. technic with Bucky diaphragm, satisfactory roentgenograms being obtained in 1½ to 3 seconds.

The gall-bladder is routinely examined by meal than usually employed, not over 6 to 8 oz. of fluid mixture, and speed. The voltage and current should be adapted to exposures of 1/10 to 1/2 second at 26 or 28 in. Change of position to oblique and vertical requires a few more kilovolts without change of the time factor.

By elevating the tube from 26 to 30 in. and removing the cone the motor meal may be followed, the voltage being gradually dropped as the barium becomes more distributed from the central abdomen or evacuated. The barium enema will require that the voltage be again raised substantially. By following this method sharply defined outlines are obtained and the time factor remains constant. Card indices are kept of patients of various thickness, each card showing the voltages required in the different postures and with varying degrees of filling and the barium enema.

In examination of the lungs and heart a 6-foot distance should be employed for postero-anterior, oblique and lateral views. Not over 1/10 second should be used as a time factor and the voltages should vary with the thickness of the patient's chest. The measurement should be made with the patient's back against the plateholder and from it to the most prominent part of the sternum. The lateral exposure is approximitely 4 times and the oblique 3 times that required for the postero-anterior.

This paper, as stated, is intended to recommend a systematic keeping of records of exposures and other matters of technic and not intended to prescribe any specific manner of examining special regions.

Summary

Good technical results can be obtained by anyone who is properly equipped, but require precision in measurement of the subject, the distance, time, current, and voltage.

Only by consulting and being guided by the records of previous good exposures either obtained by accident or experiment can duplication of results be obtained.

The most common error in judgment consists in the use of too high voltages or over-penetration.

Disregard of careful darkroom procedures nullifies other carefully observed details.

The most common darkroom faults are failure to observe the temperature of the developer and the use of exhausted solutions.

A careful card index system of exposures is one of the most valuable assets in the office.

Discussion

Dr. William G. Herrman (Asbury Park): We are very much indebted to Dr. Baker for bringing up this subject, and I trust that it will be one of the early papers published in the State Society Journal. I intend to go over it in detail myself and turn it over to my technicians. If all roentgenologists were pathologists, and attempted to carry their technic, or I should say their carelessness, into the preparation of microscopic sections, and then attempted to make a diagnosis of such microscopic slides, they would not get far. I think it is high time many of us got back to fundamentals and remembered that an x-ray tube, a patient, and a film underneath the patient, do not constitute an x-ray examination.

Dr. Baker did not take up position, but you all know that knowledge of anatomy, knowledge of projection, and proper positioning of the patient, together with a technic which can be repeated, are all essential to bringing out the anatomy you wish to show, and demonstrating whether pathology is present.

I have been amazed on visiting some of the leading institutions in the country, headed by men whose knowledge and experience I envy, to find when they put up some of their routine x-rays before me that I felt absolutely at sea because of the extremely poor quality of the technical work. It has been impossible for me to look at their films and decide in my own mind whether I saw anything abnormal or not, for that matter, whether I saw anything normal or not.

I well remember visiting a man, known to a great many of you here, in one of our eastern cities. He placed before me in the stereoscopic view box a pair of "chest films" and asked me for my opinion. I couldn't give it to him. The pictures were terrible. All I could do was try to be diplomatic. I turned to him and said, "Doctor, you will pardon me, but these are taken somewhat differently from those that I am accustomed to looking at, and I would rather not express an opinion."

He looked at me a minute and said, "They are very poor, aren't they?"

"I must agree with you," I replied.

He said: "My chief technician left the other day and I don't know anything about taking roentgenograms. I don't know the first thing about running the machine. I have a new technician and she is entirely inexperienced with this type of apparatus."

I went into his darkroom and saw there was no thermometer. He had an orderly who loaded and unloaded the casettes, placed the films in the baths, and went out and attended to some other duties, and if he heard the alarm clock, he came back and took them out, and if he didn't hear the clock, he came back when he had time.

That gentleman has been teaching physicians; he is used in consultation; I respect his knowledge of pathology; he can write excellent papers; but, I maintain that he is not a real roentgenologist and not a good technician.

I will warrant you Dr. Martland can go into his laboratory and give cards and spades to any of his technicians and beat them at their own game. I say that because Dr. Martland is an expert pathologist, and expert pathologists know their technic.

Dr. Deaver once said that there were 3 kinds of lies—ordinary lies, damned lies and x-ray pictures. That is true. You can misinterpret good films. It is a lot easier to misinterpret poor films. If Dr. Baker has stimulated no more than one man in this meeting to go back and find out whether he can improve the quality of his work, he has accom-

plished a great deal. I think this is something worth-while for us all to consider. It isn't only a question of machinery. The manufacturers are constantly improving apparatus but I have seen most horrible specimens turned out by the latest type of apparatus, and I have seen very excellent work turned out by someone, who knew his business, using old apparatus that was manufactured before the war.

Dr. H. J. Perlberg (Jersey City): I just want to emphasize what Dr. Herrman has said. I think it is decidedly unfair to expect any roentgenologist to make a proper interpretation of a picture that is poorly made. Only through the proper coördination of all the facilities at the command of a roentgenologist can successful results be produced.

I have in my darkroom 2 cards for the benefit of my technician. One statement is: "Perfection is no little thing, but perfection is made up of many little things." I think that covers the subject. The other cards says: "No short cuts allowed." Unfortunately, many technicians are prone to skimp here and there, mainly for their own convenience, and the result is poor. Each detail in the x-ray laboratory is just as important as the other. There is no sense in figuring out exposures down to 1/50 of a second, if a darkroom man is going to develop at 55° to 80° and if all the other small details are not followed. I think Dr. Baker is to be commended upon the fact that he has brought again to our minds the necessity for careful preparation of films so that we are able then to render an opinion that is worth-while.

Dr. George S. Reitter (East Orange): I think Dr. Baker's paper is one that is very timely and should stimulate each of us to follow some system of technic. As I was listening to it, I happened to recall the lack of teaching in one of the large post-graduate hospitals in New York City in this particular part of the x-ray course. Some 6 or 7 years ago, I took a complete course in that institution and it, of course, extended over a period of about 18 months. Everything was put in it, therapy and diagnosis, and we had a large amount of interpretation, with lectures. When it came to the technical end of the course, we spent 1 day in the darkroom under guidance of the technician. The doctors were then supposed to be finished roentgenologists. Whether or not that condition is true today, I don't know, but I think the technical end of x-ray work is just as important as the interpretation.

Dr. E. Reissman (Newark): I just want to say that from this discussion we can easily see that Dr. Baker need have no fear that his paper wouldn't be appreciated. If it did nothing else at all, it proved that roentgenography is still a personal equation. We are persistently led to believe the machine does all the work, and each salesman tries to tell us that his machine is better than the next one.

I had a man call me up the other day, a physician, who said, "Reissman, you ought to go down to such-and-such a manufacturer; he has a machine that makes a mastoid in 1/120 of a second, the most beautiful picture I have ever seen. You want to get a machine like that."

I am going to think that over and maybe I will try and see what I can do with my apparatus before I buy a new machine.

SYMPOSIUM ON POLIOMYELITIS

at the Annual Meeting of the Medical Society of New Jersey, held at Haddon Hall, Atlantic City, June 15-16-17, 1932

PRESENT STATUS OF POLIOMYELITIS FROM THE NEUROLOGIC POINT OF VIEW

Christopher C. Beling, M.D.,
Newark, N. J.

Poliomyelitis is a disease of deep interest to neurologists. While the treatment of poliomyelitis lies within the domain of the general practitioner and the pediatrician, the diagnostic criteria and the pathology are distinctly within the scope of the neurologist, and there is no point at which the interest ceases. We have just passed through a fairly extensive epidemic, comparable in many ways to the great epidemic of 1916, and 3 other nations, Austria, Hungary and Switzerland, have had epidemics simultaneously. The morbidity in the United States, for the first 10 months of 1931, was 12.3 per 100,000, a figure in excess of any other country and 10-20 times that of our normal.

A great deal of research has been conducted on the basis of this new series of cases, and an impetus has been given to new research; so, it is my purpose to review a significant number of recent publications in order to point out certain facts.

Etiology. Very little has been added to our knowledge of the etiology, but the most impressive scientific studies point to the presence of an ultra-microscopic virus, as worked out by Flexner and others at the Rockefeller Institute. Flexner, reviewing the experimental work done in recent years, states that poliomyelitis is caused by an ultra-microscopic organism which can be found in the nose and throat of recent patients and carriers. When this virus is applied to the nose or throat of monkeys, the disease can be reproduced. He is of the opinion that the usual mode of infection is by contact, but agrees that there have been several small epidemics undoubtedly due

to food infections—in most cases, milk. These small epidemics are characterized, usually, by sudden sporadic outbursts, followed by a number of cases within a short period of time, and no further cases are found. He feels, also, that there is evidence indicating that the adult population of this country is gradually becoming immune to this disease.

In a later article, Flexner notes that it is possible to accelerate infections and to produce a higher rate thereof in monkeys by reinfecting with a second dose after waiting for a latent period. In the same way, borderline or mild cases are convertible into severe cases.

The conviction has been growing that the usual mode of infection is through the portals of the upper respiratory system. A great deal of the evidence is experimental, but Flexner has pointed out an interesting fact which throws additional light on the subject. When a number of cases break out in a group or family they usually occur simultaneously; pointing to a common or coincidental exposure. When animals are inoculated by the intranasal route, a constant period of incubation is seen. Using any other method of infection, the incubation period is inconstant. This points to the fact that the intranasal infection is the usual route in the infection of humans.

Rosenow is the protagonist of the streptococcus theory. In a recent article, he again states that he has been able to isolate a specific organism from the throats and spinal fluids of patients. Olitsky has voiced the opinion of many other investigators using similar methods who have been unable to confirm Rosenow's work. He suggests that the yeast used in the culture media may be the source of the organism. Fremont Smith has made the interesting observation that if a streptococcus were the causative organism one would expect a reduction in the sugar content of the spinal fluid. This is not the case, for the sugar is usually in normal amount; so, we have presumptive evidence that poliomyelitis is not caused in that way.

There have been many articles dealing with the pathology of the disease. Most of them merely reiterate the well known pathologic findings. Of unusual interest, however, is an article by Burrows, who feels that poliomyelitis is a generalized lymphatic disease and that only the severe cases manifest changes in the nervous system. Our attention has been called to the gastro-intestinal symptoms on previous occasions, and Burrows believes that the mode of infection is through the intestinal lymphatics. In this connection, it is interesting to review an article written by me in 1911. At that time, I pointed out the pathologic findings in 2 cases of poliomyelitis in which emphasis was placed upon the hyperplasia of the mesenteric lymph glands and other changes pointing to a severe involvement of the abdominal viscera in general. In one there was a patchy type of hyperemia of the intestinal mucosa, and, in both cases, lymphoid hyperplasia was prominent. I postulated at that time the possibility that the alimentary tract might be the site of infection. It is, therefore, of particular interest to me to find corroboration of my views arriving some 20 years later.

I have figures at hand on the morbidity and mortality rates of the past few years. There is very little to be learned by reviewing them, other than to note that the mortality rates for the last epidemic were lower than in previous epidemics. There are, also, figures to show that the factor of severity was less; i. e., there were fewer patients with severe paralysis and deformities, and a higher rate of complete recoveries.

We have not progressed far in the matter of early diagnosis. In a very complete résumé of the subject, Leake has emphasized the importance of the systemic symptoms, since they usually precede, by many hours, the involvement of the nervous system. He points out the frequency of such symptoms as: Fever with headache; gastro-intestinal symptoms, such as vomiting; constipation; rarely diarrhea; and, abdominal pain. He notes the frequency of evidence of cerebral involvement, such as drowsiness; or, on the other hand, restlessness or irritability. The child frequently shows personality changes, is irritable, peevish, resents interference, and does not want to be petted. Two other symptoms which are very frequent and tend to confirm the diagnosis are the retention of urine and the presence of abnormal sweating—out of proportion to the room temperature or the degree of fever.

The chief cardinal symptoms of poliomyelitis, those pointing to definite involvement of the nervous system, are: signs of meningeal involvement, such as neck rigidity, Kernig's sign, hyperesthesia of the skin and changes in the reflexes. The reflexes may be hyperactive during the irritative stage, but are diminished as soon as the paralytic stage sets in. He points out the presence of twitchings and irregular tremors in the early stages of irritation.

Very little attention has been paid to ocular symptoms. In a recent article, Emmons reports ocular involvement in 29% of a large series of cases; changes consisting of ocular palsies, ptosis and pupillary changes of one type or another. The author feels that his percentage is much higher than reported in other epidemics, but feels that had all the cases been examined carefully by ophthalmologists looking for these symptoms, the figures for other epidemics would compare more closely to his own.

Treatment. When we come to this phase of the subject we are able to show more progress than in any other. In the past few years the use of convalescent and immune serum has revolutionized the treatment of this disease. It is difficult to be certain as to the true value of the newer methods, because many factors enter and obscure the final analysis. I intend, however, to review a few of the more significant articles dealing with this phase of the subject, in order to present a fair cross-section of current opinion. Using convalescent serum in doses of 25 c.c. intramuscularly, McEachern and others report 93% recovery of the patients treated in the pre-paralytic stage. Following the onset of paralysis, 40% of their patients recovered partially and 20% completely. These authors do not feel that the intravenous administration was as effective as the intraspinal. Ayers reported 90% complete recovery of patients treated within the first 24 hours; 6% were left with mild paralysis; and the mortality was 2%. Patients seen after 48 hours were less responsive to serum therapy, only 30% showing complete recovery. Hartman discusses the results in 161 patients treated by intramuscular injections of convalescent serum during the Manitoba epidemic. A much higher rate of recovery was noted in patients treated in the pre-paralytic stage. The author quotes the experiences of McNamara in the Victorian epidemic. Of 42 patients treated early, only 16 showed mild palsies and recovered completely; 2 developed severe palsies and 1 patient died within 6 hours. Of 19 patients who had paralysis before treatment was commenced, 16 had no further progress and 11 recovered completely. Fairbrothers, using an average dose of 20 c.c. intraspinally and 30 c.c. intravenously, felt that the use of convalescent serum was a distinct advance; the usual response was a rapid fall in temperature and marked improvement. Where paralysis had occurred before the serum was given, the outlook was not so favorable but it was felt that the serum might limit the extent of the lesions. He emphasized that "while the administration of serum was comparatively harmless, failure to inoculate serum in poliomyelitis might result in permanent crippling with impairment for life".

A fair number of case reports have been published in the literature concerning the use of Rosenow's serum. Rosenow and Nickel have reported good results from a serum obtained from horses that were immunized by the injection of a pleomorphic organism isolated from the nose and throat of poliomyelitis patients. In a series of more than 200 patients and an equal number of controls, the results obtained were favorable, especially among those in the pre-paralytic stage. Dickie compared the results obtained from the use of Rosenow's serum with those from convalescent serum, and found that Rosenow's serum gave 64% improvement while the convalescent serum only gave 55%. Kramer and others using convalescent serum failed to obtain any definite evidence of its value. They found that paralysis was present to about the same extent in both their treated and untreated cases.

The question is often asked, regarding the relative values of intraspinal, intramuscular and intravenous injections of convalescent

serum, and I would say that the consensus of opinion is that the intravenous method is less satisfactory than the intraspinal or the intramuscular.

Howitt found in his experimental work with monkeys, the intramuscular route was more effective than any other, both in preventing onset of the disease and in limiting the extent of the lesions.

Considering the fact that edema causes much of the damage to the spinal cord, Bradhey and Scheffer suggest the use of ephedrine intraspinally. They have had promising results in a small series of cases, and several others confirm their findings.

The mortality in the bulbar type of poliomyelitis has always been very high; due chiefly to respiratory paralysis. A distinct advance was made in the treatment of apparently hopeless cases by the use of artificial respiration and various mechanical respirators, of which the best known and most effective is the Drinker respirator.

It becomes apparent that no great advances have been made in knowledge of this disease in recent years. In common with many other virus infections, the etiology, epidemiology, and treatment are obscure. A great deal of research has been done and the results have not been startling, but small facts have been added from time to time to our working knowledge. Despite the fact that the use of convalescent serum is apparently of value, a word of caution must be said. The difficulty in diagnosing poliomyelitis in the pre-paralytic stage is quite obvious. Any treatment, the value of which is based upon the results obtained in these pre-paralytic cases, becomes immediately subject to a great deal of doubt. I feel, nevertheless, that in view of the nature of the disease and the appalling sequels, the use of any relatively harmless procedure is justifiable. It will only be by a survey of the results of treatment of a large number of patients, that we shall arrive at a clear understanding of the actual value of this or any other form of treatment.

PHYSIOTHERAPY, USE OF RESPIRATORS AND ORTHOPEDIC TREATMENT, IN POLIOMYELITIS

B. F. Buzby, M.D.,
Camden, N. J.

Entry of the orthopedist into the treatment of a patient suffering from acute anterior poliomyelitis should occur very soon after onset of the disease.

In the acute post-paralytic stage the main object of treatment is to prevent deformities from the contractures of non-paralyzed muscles. A careful, minute and detailed examination should be made to determine the individual muscles involved and the extent of the paralysis, whether total, partial or slight. The possible effect of such partial paralysis must be evaluated on the basis of whether opposing muscle groups are involved and when deformities might ensue. Paralyzed parts must be put at absolute rest in splints, in that position best suited for rapid normal recovery of the muscles involved and, at the same time, in that position where muscle balance can be best maintained. As a rule, the so-called "mid-position of function" is usually desired; for instance, where there is rather general paralysis below the knee, the foot should be splinted at right angles to the lower leg and midway between varus and valgus, and the knee should be kept in full extension because of the origin of the gastrocnemius from the femoral condyles. Again, in case of shoulder girdle involvement, where the deltoid is most commonly affected and the axillary fold muscles seldom so, the shoulder should be kept at right angle abduction to permit the deltoid to recover all that it will without the constant pull and stretch caused by its opposing muscle group.

By *rest* is meant—rest of the entire body flat in bed, as well as the grossly involved extremity or extremities. This must be especially true where the upper extremities, back and abdomen, are affected.

Scoliosis rapidly appears, even in mild paralysis of either back or abdominal muscles, if

the weight of the upper-half of the body is superimposed too soon after onset of the disease upon the lower-half through weak trunk muscles. Thus, early, intelligent splinting and support is of prime importance. The involved parts must be kept warm, also, either by external dry heat, as given by electricity, or the wrapping of the parts in cotton, or both.

Practically without exception, severe pain, in the muscles involved in the paralytic process is part of the disease. This is made worse by active or passive motion or handling, and is another reason for rest of the involved part. This pain can be relieved partially by coal tar products, but occasionally opiates are necessary. In this stage of the disease it is of extreme benefit to immerse the whole body in a hot tub bath for ½ hour once or twice daily. It helps relieve the pain and does relieve spasm of nearly non-involved muscles.

Massage should never be given while the muscles are sore, nor should active motion be permitted. Properly given at the correct stage, massage is the sheet anchor in treatment of this disease, yet, if given early, while the involved structures are sore, it will markedly delay the tendency to spontaneous recovery of the muscles.

The value of inactivity is, as it were, often extremely difficult to "put over" to the parents or friends of the patient but a good rule is to assure them that without massage considerable recovery will take place and, later, with it, much more. Usually, the rule to be followed is that no massage or other physiotherapeutic agent, except external heat and hydrotherapy, should be used until 2 months has elapsed after disappearance of all soreness of the muscles. The cause of this soreness is thought by some to be local congestion incident to disturbed nerve supply; by others, to be involvement by extension of the pathologic process in the cord from the anterior and motor cells to the posterior and sensory cells. Some part of it may be due to toxic collections in the muscles from inactivity by splints or other appliances; and still others feel that it is a polyneuritis caused by the toxins of the disease.

The use of respirators in infantile paralysis is of value only in those cases where there is paralysis of the intercostal muscles and diaphragm, as well as the other accessory muscles of respiration. They are of no value in the bulbar type of paralysis and, of course, there is no indication for their use in peripheral paralysis. By far the most satisfactory and most widely used Respirator is the Drinker apparatus first described in the A. M. A. Journal of May 1929 and again in October 1930. It consists of a large sheet metal tank equipped with a comfortable bed and mattress. The patient's head protrudes through a flat soft rubber adjustable diaphragm attached to the body of the Respirator which makes an air-tight seal about the neck. Its efficiency depends upon electrically driven blowers and valves which change the pressure in the tank from a few cubic centimeters of negative pressure to normal atmospheric pressure; the negative pressure inducing inspiration; and the atmospheric pressure, expiration. Both the rate and depth of respiration are controlled by observation of the operator on the colored water in a U tube gauge.

As a rule, a negative pressure of 12-18 cm. of water gives adequate ventilation in complete respiratory paralysis and it is better to use a negative pressure of sufficient amount only to prevent cyanosis or obvious respiratory distress than too much. Without stopping the pumps it is possible to attend to all bodily functions in the apparatus but the noise of the motors, while not excessive, prevents use of the stethoscope. It is of extreme importance to change the patient's position in the respirator often, to prevent hypostatic pneumonia. In its use, if the patient does not respond to the respirator and does not breathe in rhythm with the machine, it is doing no good. Patients may be kept alive in the machine indefinitely but spontaneous recovery slowly takes place and the time out of the respirator may be increased as the normal respiratory function improves and muscle power increases.

Local rest should be kept up until massage is begun. Then, metal braces are applied to the involved parts, to prevent deformities and to protect the weak or paralyzed muscles from being over-stretched. No matter where in the body it exists, over-stretching of a paralyzed

muscle will prevent its rapid recovery and often the opposing non-paralyzed group will become so foreshortened by continuous contraction that surgical procedures must be undertaken early to permit possible normal use of the part. This is most commonly true in contractures of the tendo achilles, causing a paralytic equinus and subsequent flat foot; in contractures of the hamstrings, leading to collapse of the knee on weight bearing; and in contracture of the hip flexors, causing a compensatory hollow back. If the patient in point has progressed well and massage is being given and braces worn to prevent damage to paralyzed parts, this period of convalescence usually covers 2 years.

The value of diathermy, baking, faradism and galvanism, is seriously questioned by many writers but, should it be used at all, it is during this 2-year convalescent period that it is most useful. Diathermy has been offered by some as of value if applied to the spinal column early in the disease. Probably its good results are accounted for in the normal spontaneous recovery that follows careful protection early in most cases.

Baking is of value only in so far as it warms the part, since the skin temperature of the paralyzed part is always much lower than its fellow and it is because of this that in winter much woolen clothing should protect the part; otherwise, frost bites and chilblains are common. It is in cold weather that preliminary baking, to thoroughly warm the part before massage is given, shows the best results, but it does so only by making the massage more efficacious.

Of all electric treatments, galvanism, either of the mechanically surging type, or interrupted by the operator, is used most commonly. The objection to this modality is that it so often overtires muscles which are already the seat of the reactions of degeneration, or have so little nerve supply left that the period before fatigue is very short. Practically all observers feel that while electricity is of slight value, massage, and the holding of the affected part in position to prevent deformities, allow recovery to take place more rapidly than with any other course of treatment.

Hydrotherapy, as already indicated, is of value early and in the shape of hot baths. Later, whirlpool baths are stimulating; but by far the best application of water is by swimming. Here, the paralyzed parts are buoyed up by the water, the action of gravity is in large part eliminated, and active motion is encouraged and carried out with ease. Some patients who *walk* only with great difficulty are able to *swim* long distances. Lately, massage under water has been advocated but this is of far less value than the muscle reëducation obtained in water whether by swimming or graded exercises.

Except for tendon lengthenings, or tenotomies to overcome contractures and acquired deformities, no surgical procedures should be undertaken until at least 2 years of careful treatment have elapsed after onset of the disease. Some recovery often takes place after this period with persistent massage but, as a rule, one can satisfactorily evaluate the condition and its needs for reconstruction surgery at this time.

Since it is a fact accepted by most orthopedists—that tendon transplantations alone are unsatisfactory in their end-results, in that they all stretch or give way within a few years, some type of joint stabilization by a bone operation must also be done. In the feet and hands, where most of these procedures are done, arthrodeses, or joint fusions, are the operations of choice. It is also recognized that bony union in those operations does not take place if the child is too young when it is done. An arbitrary age limit of 9 or 10 years has been set, before which one cannot be sure of a satisfactory arthrodesis. Accordingly, many patients spend several years in braces being treated by massage before becoming old enough for orthopedic reconstruction.

Often accompanying the arthrodesis, tenotomies or capsulotomies must be done to permit of better function as a result of the stabilizing operation. Osteotomies for knock-knee, or to produce back-knee, are done to improve alignment of the paralyzed leg.

The most commonly performed fusion in the foot, is the Davis subastragalar arthrodesis to correct the varus or valgus deformity there, which includes the destruction of the astragalo-

scaphoid joint as well as the astragalo-calcaneal joint.

The horizontal section of Davis is done for dangle-foot, or for pes calcaneovalgus or calcaneovarus, and consists in carrying the destructive operation on the astragalo-calcaneal joint forward in a horizontal plane through the scaphoid and, after separating the lateral ligaments of the ankle, the lower portion of the foot is forced back on the overlying astragalus ¾ in. or so, after which, the weight is borne more forward on the scaphoid. When present and active, the peroneal tendons are often inserted into the os calcis. In place of this operation astragalectomy is done by some but since it shortens an already shortened leg, and is often followed by irremediable pes varus, it should not often be done.

For toe drop, or pes equinus, the bone-block operation of Campbell is done. Here, a mound of bone is built up on the superior surface of the os calcis posteriorally, made up of bone chips obtained from the accompanying subastragalar arthrodesis, which mound impinges against the posterior lip of the tibia, thus preventing the equinus deformity.

A midtarsal arthrodesis, where the astragaloscaphoid and calcaneocuboid joints are fused, is done for metatarsal equinus. Fusion of the entire inner row of tarsal joints, e.g. astragaloscaphoid, scaphoid-inner cuneiform, and internal cuneiform-first metatarsal joints, is also done for this same condition, and, when present and active, the extensor proprius hallucis tendon is inserted into the inner side of the first metatarsal, thus aiding in active dorsiflexion of the foot.

Arthrodesis of the ankle is a procedure with few indications because of the increase in limp which follows. It is done also for dangle-foot or flail-foot.

Cuneiform tarsectomy is the procedure of choice where deformity of the foot has become bony through years of lack of support, and this is done disregarding any joints that it may cross and the necessary bony wedge removed to give the foot a normal contour and weight-bearing surface.

A very disabling condition occurring at the knee is paralytic genu recurvatum for which many operations have been devised. The procedure lately described by Mayer, of a tibial graft extending from the articulating surface of the tibia to the posterior surface of the patella, giving a definite bony block to hyperextension, is a valuable addition to the orthopedists armamentarium and gives unbelievably good results.

Fusion of the spine after the method of Hibbs, following about 2 months of lateral traction in bed to correct the deformity, offers the best results in the treatment of paralytic scolosis. Rarely is it possible to so strengthen the back muscles, by any other treatment, as to be able to overcome the poliomyelitis structural changes in the back.

In the hand, a most crippling minor paralysis takes place in the thumb, with loss of adduction and opponens power, which causes the thumb to rotate and become a fifth finger. The results of arthrodesis of the first trapeziometacarpal joints, with the thumb fused in its proper plane in relation to the fingers, are phenomenal, for the flexors then can act in their full power in opposing the thumb to the finger tips.

Transplantation of the origin of the supinator longus, or the entire wrist extensor muscle group, up the humerus from the external condyle gives us a good substitute for a biceps, or, if these are too weak to function thus transplanted, arthrodesis of the elbow will permit them to function better in their normal position.

Arthrodesis of the shoulder in the position of 60° abduction of the humerus on the vertebral border of the scapula, will permit the trapezius to take up the function of the missing deltoid in abducting the whole shoulder girdle, while gravity will bring it to the side.

Thus, it can be seen that while certain general rules can be followed in substituting unparalyzed muscle function for that which is lost, bone operations are the basis of all paralytic reconstruction operations and tendon transplantations are of secondary nature, as it were, depending on a solid foundation on which to work in their new locations.

Results of the operations above enumerated are uniformly good if properly done and if the after-care is sufficient. This, however, is important. A good rule to follow is to cast

the part for 3 months following operation, thus to permit fusions to become solid and the tendons transplanted to become reëducated. Braces are then applied and worn up to 1 year after operation when, as a rule, they can be discarded forever.

Atrophy, both in circumference and length of the paralyzed part, always takes place where there is not rapid and complete recovery, and even when this happy eventuality does apparently take place, there may appear later, after many years, a mild claw-foot or metatarsal equinus which will require surgery for relief of the accompanying pain on weight-bearing.

In this most terrifying disease, where children, especially, but adults also, may be stricken down, from perfect health to what may become a state of permanent crippling, over night, it is gratifying to know that by persistence in intelligent conservative treatment plus proper timely surgical intervention, many are made to fill very useful, comfortable, self-supporting and happy places in the world.

EARLY DIAGNOSIS AND TREATMENT OF ACUTE ANTERIOR POLIOMYELITIS

L. C. Rosenberg, M.D.,
Newark, N. J.

It is my purpose to try to simplify the picture of poliomyelitis in its pre-paralytic phase and to discuss those symptoms and signs that have been most helpful to me in reaching an early diagnosis.

In a typical case of the disease the onset is rather sudden. The child rapidly becomes feverish and drowsy. In most cases this drowsiness becomes an outstanding symptom. The patient can easily be aroused from this stupor but, when awakened, is strikingly irritable and restless. He particularly does not want to be annoyed, and just as soon as he is left alone relapses into a comatose state. The mind is clear despite this drowsiness and if the child's coöperation can be engaged, he will complain of 2 significant symptoms—occipital headache and pain in the back. Starting to examine the patient, the physician may or may not have poliomyelitis in mind, but he will suddenly get the lead as he observes the movements of the child. When he must ask the patient to sit up or turn over, it becomes evident immediately, as the child responds, that there is disinclination to flex the spine, and as the attempt is made to assume the upright position, he extends his arms and rests on his hands placed far behind his back. If the patient should now be asked to fold his arms, he will reluctantly try and quickly revert to his original position. The characteristic posture of supporting himself that the child takes is known as Amoss' sign. If asked to turn over on his abdomen, it will be evident that the movement is painful, and while he is turning it may be noticed that the spine is held straight and stiff as a poker-back. When I have thus observed that there is pain on motion and on handling a child, it has been my practice to take him out of bed, regardless of the temperature, in an attempt deliberately to elicit and verify this pain and rigidity of the spine. This may be accomplished by directing the patient to bend over and touch his toes, and at the same time cautioning him against bending his knees. He will be unable to do so in a true case of poliomyelitis, or if he can, as is possible very early in the disease, he will do so with great difficulty. As the child goes through this procedure, it will be noticed that the back is held rigid and straight and all motion is at the hips. This resistance to anterior flexion is known as the "spine sign" and is the most valuable diagnostic clinical sign in the pre-paralytic stage. To determine this sign in infants, it is best to turn the baby over, face downward, with both lower limbs grasped in one hand and the other hand placed on its back; the spine is first rotated from side to side, and then passively flexed both laterally and anteriorly, in an attempt to elicit pain and resistance to motion. The "spine sign" having been observed, the diagnosis may be confirmed by lumbar puncture.

There are other helpful signs and symptoms in recognizing the disease: Stiffness, and pain in the back of the neck, are early signs. A distinct tremor of the fingers is of diag-

nostic value; a tremor evidently due to irritation of the anterior horns prior to beginning degeneration. Hyperesthesia is a prominent symptom early in the disease; tenderness usually being present along the spine and down the legs. Muscular pain and twitchings are commonly located in one or more groups of muscles. Hyperactivity of the patellar reflex manifests itself early. Gastro-intestinal symptoms frequently appear, and vomiting or diarrhea may be so marked as to lead one to believe this disturbance alone is responsible for the child's fever. Sweating is quite common, especially in the more severe cases. The eyes show significant changes; the sclera and the cornea are glazed and there is circumorbital puffiness; while in other infectious diseases the eyes are usually bright and shiny.

Regarding the course of the disease, the pre-paralytic period lasts for a varying number of days. In the majority of instances, paralysis is evident by the fourth day, if it sets in at all, and after the eighth day there seems to be very little danger of its occurrence.

Diagnosis. Recognition of poliomyelitis in its pre-paralytic phase is admittedly difficult, because all cases do not run the typical course described; and, furthermore, it is not possible to make the diagnosis until the beginning of meningeal irritation. The disease cannot be detected by any means as yet known during the period of systemic invasion.

Missing of atypical cases is likely and entirely excusable. A case may run so irregular and so indefinite a course that the patient has no noticeable fever, no complaint of headache, no stiffness of the neck, nor any pain in the back, and paralysis is the first manifestation recognized. When the disease runs such an atypical course, it is humanly impossible to diagnose it in the pre-paralytic stage.

However, too often the typical cases are missed. Consider the feeling of a physician who has had under observation a child ill with fever for several days, and then, on his third or fourth visit, discovers a paralyzed extremity. How chagrined he must feel, especially when an inquiring past-history reveals that the child had a persistent headache, stiffness of the neck, a constant pain in the back and inability to sit up, to all of which no attention was given, and when no attempt at any time was made to elicit the spine sign!

The most valuable symptoms of poliomyelitis in its pre-paralytic stage are those directly referable to the spine, namely, occipital headache, stiffness of the neck, constant pain in the back, a poker-back attitude, resistance to motion of the spine and hyperesthesia of this region. Of significance also, is the presence of fever, Amoss' sign, and distinct pain when the child is handled during examination. In my experience, this last sign has been of utmost importance.

If the clinical manifestations are correlated with the characteristic spinal fluid findings, diagnosis can then be made with a fair degree of accuracy.

Prognosis. The prognosis as to life has varied strikingly in past epidemics. It is obvious that certain outbreaks have been more virulent than others. Statistics, however, show the average death rate to be about 15%. The mortality rate though is in reality not quite so high as this figure would indicate, since such data were based only on cases that have been diagnosed from the paralytic symptoms. The abortive type, and the cases of slight paralysis, have escaped recognition. When due allowance for such error is made, the prognosis as to life can be considered more favorable.

Under this heading it is extremely interesting to note that there is no relation between the severity of the systemic symptoms of a case of poliomyelitis and the development of paralysis. Frequently, in the cases of mildest onset the patients will have extensive loss of power, while those cases that are severe and show fulminating prodromal symptoms may subside rapidly and the patients escape with only slight or even no paralytic lesions whatsoever. There is, thus, no way of anticipating the occurrence of paralysis. Likewise, the cell count of the spinal fluid is of no prognostic significance. The patient with a cell count of 1000 may make a complete recovery and, conversely, the one with a low count may succumb.

Finally, regarding paralysis itself, in the great majority of cases it develops by the eighth day of illness, and if it has not shown

itself by that time, one need not be apprehensive about its appearance.

Treatment. The curative value of human convalescent serum, in the treatment of poliomyelitis during its pre-paralytic stage, is open to question. Statistical studies of epidemics occurring in recent years are conflicting in the evaluation of the efficacy of this form of therapy; some observers claiming distinctly better results with use of the serum than others, while some obtain better results without it, and some note no difference.

Those who are opposed to serum treatment give the following reasons:

There are numerous instances in which the physician proudly makes an early diagnosis of poliomyelitis, administers the serum quickly and then watches the patient go on to disaster. It is highly improbable, it is pointed out, that the serum as it is customarily administered ever reaches the site of the lesion in the anterior horn. Doubt is expressed as to whether serum given by the intravenous route passes through the walls of the blood vessels located in the spinal cord into the perivascular system. Furthermore, when the secretion, circulation and absorption of the spinal fluid are considered, it is doubtful, too, if the serum injected intraspinally ever penetrates to the pathologic process in the gray matter. Certainly, in view of the presence of immune bodies in human convalescent serum, the results of the injection of this fluid should be more satisfactory.

Recovery from poliomyelitis, it is shown, cannot always be attributed to serum therapy, for it is pointed out that a certain number of patients will recover without recourse to it. Also, paralysis in a given case can regress and even disappear entirely without the use of this agent. Furthermore, it is not possible to state how many patients treated with serum would have remained free from paralysis without its use. The success of serum in epidemic meningitis has influenced many individuals to have faith in the poliomyelitis serum. However, the contrast in the pathologic processes must be borne in mind.

Those in the school that upholds the serum therapy, emphasize the following points in their contention:

The use of human convalescent serum in the treatment of poliomyelitis is based on scientifically sound experimental proof. Laboratory workers have shown that this serum has actual viricidal power and it will prevent paralysis in infected monkeys. This, in their opinion, is sufficient grounds to warrant its use, and logical reasoning is presented to explain the failures. It is emphatically pointed out that the serum as used today is not a standardized product. It may vary greatly in strength; in some instances being capable of neutralizing the virus in high dilutions, and in other instances entirely impotent. This important observation was made by Shaughnessy and his co-workers. In experimenting along these lines the authors tested the blood of 7 persons who had poliomyelitis and in only 4 of them was the serum found to be viricidal. It is essential, therefore, to limit ourselves to the use of human serum which has been tested for potency. Moreover, it is claimed that some failures are due to inadequate dosage. The amount recommended is 20 c.c. intraspinally and 60 c.c. intravenously, and if high fever persists the intravenous dose should be repeated.

Some authors attach much importance to the necessity for using serum intravenously. In support of their opinions, several facts are pointed out: first, that the anterior horns are richly supplied with blood vessels; and secondly, microscopic examination in the acute stage of poliomyelitis shows infiltration in the tissues just outside of these blood vessels. Consequently, the intravenous method offers a direct route to the site of the lesion. Because of these anatomic and pathologic considerations, immune serums given in this way should be more effective than when given intraspinally.

Unsuccessful results are due in some instances to late administration of the serum. To be effective, it must be given early in the pre-paralytic phase of the disease. If the serum is administered after the virus has been securely entrenched within the anterior horn cells, then no benefit can be expected from the serum. Andrews has shown that when a virus of the filtrable class has made its biologic union with the threatened tissue cell, it is no longer within reach of a neutralizing serum.

Another important point is made in reference to late administration of serum. Patients may be erroneously classed as pre-paralytic, whereas, in reality, they already have a definite muscular weakness which was not detected. Serum given to such patients will obviously be of no avail, and this type of case counts unjustly against the value of serum.

Immediately before the stage of muscular weakness sets in, there is the period of ataxic tremor and muscular twitching. Serum given at this time may or may not be too late to be effective. Finally, in answer to those observers who claim as good results without the use of serums as with it, the fact is presented that epidemics vary greatly in their severity. In certain outbreaks the mortality is low and there are comparatively few paralytic results, so that many patients would recover without treatment. In other epidemics the reverse is true. The merits of serum therapy should be judged, it is claimed, by its effect in virulent epidemics only.

To summarize, the value of human convalescent serum is as yet undetermined but the trend of opinion is in its favor. Until its effectiveness is disproved, it should not be abandoned. Irrespective of the different opinions, hope lies in the fact that the serum when given with poliomyelitis virus to monkeys prevents the disease in these highly susceptible animals. The serum used must be potent as determined by viricidal tests. Its use cannot cause any harm and the patient should be given the chance of possible benefit from it. When administered, it should be given in massive doses by the combined intraspinal and intravenous routes and must be given early.

Supplemental therapy. In addition, 3 other therapeutic measures might advantageously be employed, all directed at overcoming the pressure on the nerve cells in the anterior horn caused by infiltration and edema. Intravenous infusion of 50% glucose is recommended by Ferris, Elliott and Stookey for this purpose. These authors state that the occurrence of extensive and severe paralysis which clears up or improves rapidly within a few days suggests that at least part of the acute manifestations of poliomyelitis may be due to the effect of edema, and it seems logical to employ this form of therapy.

Spinal drainage is enthusiastically advocated by some. Diveley states that the effect of spinal drainage on the acute symptoms in his series of cases was almost phenomenal, the symptoms disappearing, for the most part, a very short time after drainage and only appearing again when the intraspinal pressure rose above normal. Other authorities also stress its value in reducing the edema and removing some of the toxins. It would seem to me sound therapeutics to keep the spinal fluid pressure as nearly normal as possible by frequent tappings and I believe the use of drainage should be encouraged. The third agent employed with the same objective in mind, that is, relieving engorgement and reducing pressure on the cells, is the use of ephedrine injected intraspinally. Bradhey and Scheffer claim encouraging results by this method.

One cannot well dismiss this subject of serum therapy without discussing the use of the normal human serum and hyper-immune animal serums. Shaughnessy reports that antibodies present in normal immune serum exceed those present in convalescent serum. This is amazing, and if his findings are confirmed, the use of such serum will supplant the present method of drawing blood from recently recovered patients.

Immune serums prepared by injecting the virus of poliomyelitis into horses, goats and sheep, have already been made. Startling results are claimed, but we must be skeptical in accepting these reports, for we must not ignore Flexner's observation that the antigenic response to the virus is practically negative.

Immunization. During times of epidemic activity the physician is constantly pressed for advice regarding ways and means of offering protection to children. Active immunization with poliomyelitis virus is so remote from perfection, and so fraught with danger, that its use is out of the question. Passive immunization with convalescent serum has 2 serious drawbacks to its general use; its protective power is too transient and the supply is too limited. Nevertheless, during an outbreak of the disease it seems worth-while to

advocate the use of mixed normal serum taken from both parents, the injection to be repeated 2 or 3 times during the epidemic. The use of such serum is justified by the fact that normal human serum taken from the majority of urban adults has the same action on the virus of poliomyelitis in the test tube as does convalescent serum. Therefore, the grounds for using normal serum are on an equal footing with those for convalescent serum.

DISCUSSION

Dr. William London (Perth Amboy): There was one point not discussed this morning and that refers to cases of acute poliomyelitis having either low or normal cell counts in the spinal fluid, and the question of a normal or low cell count as regards prognosis in acute poliomyelitis cases. I had the experience of having 2 children in the epidemic this past summer, both of whom had low cell counts; 1 with a count of only 9 and the other only 50 cells. Both died within a period of 5 days. Both had dysphasia, paralysis of the muscles of swallowing, and developed paralysis of the upper extremities. I have talked with some of the men in New York City who saw a rather large number of cases this summer, and some of them saw patients with poliomyelitis but normal or very low counts, not over 50 cells, and they all had the bulbar type of poliomyelitis, and a fatal outcome.

Dr. Ellis Smith (Superintendent of the Essex County Isolation Hospital): These papers have been very interesting and I have enjoyed them very much. However, as to the epidemiology and prophylaxis of poliomyelitis, and as to the specific treatment, we know practically nothing as yet.

I was particularly interested in Dr. Rosenberg's statement as to the potency of convalescent serum, or his attempt to determine whether or not convalescent serum is potent. He inferred, at least, that we do have some check on this. It is new to me and I am glad to learn about it. You may remember that last year the state undertook to collect blood and this blood serum was put up by the biological laboratories, and the serum was pooled so that we had no method of determining whether it was potent, and if so, how potent. I will report about a number of patients we had at the Essex County Contagious Disease Hospital and what we did.

There were some 200 sent to us, either definitely diagnosed as poliomyelitis or as possible cases for observation; 148 of these cases proved to be poliomyelitis. Of those sent in, 47 were on the borderline of the pre-paralytic type, or just past that transition stage, just going over to the paralytic stage after the ataxic period.

Some writers have described the ataxic period as that time when the patient makes a final plea to be treated with convalescent serum before the paralysis begins; and 42 of those pre-paralytics were treated with convalescent serum, mostly in the stage before the ataxic period. All but 5 were treated by giving the serum intraspinally and intramuscularly. As to that treatment, we always tried to give a slightly less amount of convalescent serum than spinal fluid removed, so as not to increase the pressure, and of course it was always given by gravity. The usual dose was 15 c.c. into the spine and 20 c.c. into the muscle, repeated on 2 successive days. In 5, the serum was given intravenously and there was 1 particularly that reacted badly. I think that was to be expected, for we sometimes get a reaction whether the serum is given intraspinally or intravenously. Of course, we have had a number of reports from various experimenters who favor one method or the other. The main reason for giving the serum intravenously to those 5 patients in preference to the routine intraspinal and intramuscular injections, was the fact that you may have a condition which you feel rather certain clinically is poliomyelitis but which the spinal fluid will not bear out, and you are not certain about the diagnosis. If the serum is given intraspinally, the spinal fluid is lost for further laboratory examination and for proving your diagnosis of infantile paralysis. Of course, you know that there is a very high cell count after giving the first dose of serum intraspinally. By giving it intravenously, there can be further study of the spinal fluid on the second or third day and the diagnosis confirmed.

Out of the 42 patients given serum, there were 8 (19%) who subsequently developed paralysis. All of those were proved cases, both clinically and by laboratory findings. If we have 19% of patients treated becoming paralyzed, assuming that 50% of all become paralyzed without treatment, we still have evidence of the good effect of serum in some 31%. Of course, it may be said that this cannot be proved. It is a fact that nobody can say whether a particular patient will become paralyzed, and we know the severity of the epidemics and that varying epidemics will disagree in the percentage of paralysis resulting. Some reports have shown anywhere from 60% to 80% of all patients as becoming paralyzed. Another report will vary down to the point of 30-35% of paralysis. If we try to strike a happy medium, which would also be about in accord with the mild epidemics, we might say that 50% of all infantile paralysis patients become paralyzed, I think we could assume that our convalescent serum treatment is responsible for 31% improvement.

Dr. K. Rothschild (New Brunswick): At the last meeting of the Association for Research of Nervous and Mental Diseases a paper was read, bringing out the idea that the virus of herpes has been considered responsible for infantile paralysis. I just wish to mention that as an addition to Dr. Beling's paper. It seemed, at that time, that there was some experimental evidence in favor of that theory.

As to the question of some of the rarer symptoms, we all see, especially in neurologic clinics, a number of cases which we diagnose as spastic infantile paralysis without being absolutely certain that this diagnosis is correct. I think there is more of a polio-encephalitis connected with the average poliomyelitis case than we usually assume. Some patients may represent a cerebral form of poliomyelitis. Besides, the classification of anterior poliomyelitis, simply considering it as an infection of the anterior horns, is not quite as correct as has been considered because sensory symptoms are often predominant and obvious, and so are symptoms of pyramidal tract involvement, especially in the beginning. Caution should be sounded in view of such findings. We might overlook a case of infantile paralysis if we confine ourselves too strictly to the diagnosis of acute anterior poliomyelitis.

One more word about a certain attitude that we are liable to take during the period of an epidemic. Two patients come to mind. One came up in a clinical conference and I am quite sure it was a case of serous meningitis and not poliomyelitis. The other case was that of a young colored man,

and concerning him I gave the opinion that it was tuberculous meningitis and not poliomyelitis and, as it happened, I was proved right at autopsy. The symptoms were certainly misleading and one of the men who saw that patient is here today and may be able to add a word in this particular respect. All of these cases of polio-encephalitis, poliomyelitis, tuberculous meningitis and quite often cases of epidemic encephalitis are difficult to differentiate. One case I diagnosed as an encephalitis, which proved to be a tuberculous meningitis and, I am sure that if I saw such a patient again today I would diagnose the condition as encephalitis again because he had all of the ocular symptoms that are commonly associated with encephalitis. Tuberculous meningitis in the absence of a clear history could only have been a secondary thought, and yet it was proved so at autopsy.

Dr. F. W. Lathrop (Plainfield): I am quite enthusiastic about this symposium. I think this presentation has been splendid. The epidemiology of poliomyelitis interests me particularly. I think we are all going to realize sooner or later what a wide-spread disease this is, with the almost universal immunity among adults, and the large number of patients having gastro-intestinal upsets which occur during these epidemics of poliomyelitis. I imagine that we have all had the same experience of having a great number of cases last fall diagnosed as intestinal indigestion or intestinal grippe, for want of a better term, which were probably cases of poliomyelitis without central nervous system involvement. The feeling in my mind is very definite that it is a general systemic infection that only occasionally results in involvement of the nervous system. It spread apparently through normal adult contacts in the beginning of our epidemic. There was a fairly extensive epidemic in Brooklyn before we had any cases and our first several cases—whether it was a coincidence or not—occurred in families who had had recent visitors from Brooklyn.

In the administration of the serum in the preparalytic stage, it seems to me that since there is some question as to its efficiency, and since the physiologists tell us that serum inserted intraspinally has to be absorbed into the lymphatics and then into the blood, and then excreted into the perivascular spaces to be effective—it seems to me that the intravenous or intramuscular route is to be preferred.

Dr. C. A. Pons (Asbury Park): I think the greatest advancement that will come in poliomyelitis is not by way of developing any specific therapy but is going to be along the lines of preventive immunity. Dr. Flexner is now able to immunize monkeys, though not with the degree of safety that he had looked forward to, some contracting the disease during the process. The problem is, perhaps, one of developing some suitable method to diminish the virulence of the virus.

With reference to the etiology of this condition, Dr. Paul, of Yale Medical School, gave us at the last meeting of the Society of American Physicians, some very interesting facts. The nasal washings of the abortive cases were far more virulent than those in well-developed cases; so, there is a fine point of warning in the isolation of the atypical or mild cases.

I quite agree with the last speaker, that nerve involvement is simply a complication of a systemic infection. I have been interested in poliomyelitis from the laboratory diagnostic standpoint, and of course I have had the usual experience with the cytologic examination of the spinal fluid. Using the Takata-Ara test we have obtained evidence of meningeal involvement much earlier than by other laboratory methods. The technic, which is very simple, was published in the Journal of Laboratory and Clinical Medicine in August, 1931. I do not say it is diagnostic, but it is a fine addenda.

As to the clinical diagnosis of poliomyelitis, that is, as you all know, sometimes a very difficult problem. Only 2 or 3 months ago I saw a case with rapidly advancing nerve involvement, a typical case of poliomyelitis except that there was no "polio" in the vicinity; and the child had, really, chicken-pox. The final diagnosis was chicken-pox myelo-encephalitis.

As to the use of serum, Dr. William H. Parks told us at the last meeting of the American Society of Physicians that horse serum is no good. He developed a horse serum that apparently was of no value. He does not think much of the convalescent serum, but, finally, some one asked him if his child had poliomyelitis whether he would want convalescent serum used, and he said *he would* on general principles. I think that tells the story.

It is rather difficult to estimate the value of serum used intraspinally. I agree with the last speaker that often it is responsible for an aseptic meningitis, which may be rather severe. In one instance where I administered convalescent serum, the serum did more damage than the disease itself. On the other hand, one of the most successful transfusions I have ever done was in a case of poliomyelitis with bulbar symptoms and coma; yet, rapid and complete recovery ensued, following this procedure.

Dr. J. Lynn Mahaffey (Director of Public Health): All down through the discussion of this symposium, I notice that the speakers are inclined to say —"We doubt the value of convalescent serum, little may be expected of its use, etc.," but one has said it has no value. Its value is quite difficult to determine, but I believe in the absence of a better proved treatment, convalescent serum is the procedure. I would like to tell you of the activities of the New Jersey State Department of Health in the epidemic of anterior poliomyelitis during July and August of 1931, comparing the death rate with the epidemic of 1916.

In 1916, there were reported to this Department 3973 cases of anterior poliomyelitis with 1138 deaths, or a fatality rate of 29% of cases reported. In 1931, there were reported to our Department 975 cases with 145 deaths, or a fatality rate of about 14%. The death rate for 1931 was 50% of that for 1916. Many explanations may be given for lower death rate in 1931, such as milder epidemic, less virulent infection, better care and treatment, etc.

After reviewing hundreds of returned questionnaires which were enclosed in finished serum packages, our Department would be very reluctant to state this serum has no value in treatment of this disease, and possibly it may have lessened our death rate during the 1931 epidemic. Some of the New England states have used convalescent serum with apparently good results.

This serum cannot be purchased, and, consequently, this state was compelled to manufacture its serum. An appeal was made to the Governor and the State House Commission for funds to collect blood, transportation charges, purchase of containers, etc. A sum of $5000 was given us. Letters were sent to the physicians of the state (3600), asking for names of persons who had recovered

from this disease, and who would volunteer blood for preparation of convalescent serum. After a wait of 7 days, we had letters from 3 physicians—no volunteers. Possibly due to the fact that this appeal was made early in the epidemic, and that little attention had been given in the press up to this time, many physicians did not realize fully the true condition. An appeal was made to 563 Boards of Health of the state, and to the Crippled Children's Commission. We had 663 volunteers in 7 days.

A total of 26 gallons of blood was obtained, being collected in several of the larger towns and cities of the state, brought to Trenton, Wassermann tested for contamination. Our Department was too much over-crowded in our laboratories to attempt to manufacture serum. Serum was prepared in 20 c.c. vials by the Squibb Laboratories in New Brunswick. And 10 days after the epidemic began in New Jersey the finished product could be obtained from our Department of Health in Trenton, and 18 days afterward from 16 distributing points throughout the state where we had thousands of these vials for free distribution.

Not one cent was paid for blood, nor transportation fees, of donors in the state. A neighboring state spent upward of $75,000 for blood, and paid $50 per pint for much of the blood collected. I was much embarrassed by the fact that we had not given some remuneration for blood obtained, and suggested to the State Board of Health that this be done. Mr. Buch, of the Crippled Children's Commission, advised against this, saying he believed no donor would accept money. I got in personal touch with 5 donors, and much to my surprise, every one refused to accept any money. We used $2410 for salary of one new employee, who collected blood and distributed serum, to pay for broken glassware, and for hotel and travelling expenses. The remainder has been returned to the State Emergency Fund. We are indeed grateful to the physicians of New Jersey, to the Municipal Boards of Health, and to the Crippled Children's Commission, for their activities in this work.

The State Board of Health craves a closer relationship with the New Jersey State Medical Society. We believe we can be of service to your members, and I know you can aid us greatly in our endeavors to preserve and maintain the health of the people of this great state.

THE OLD STUFF STANDS

By Berton Braley

Although, as through the world he plodded,
It's said that Homer sometimes nodded,
Note this about that poet-roamer—
It wasn't nodding made him Homer!

It's true that Alexander drank
And was at times a sot, a tank,
But set this also down, with candor,
It wasn't drink made Alexander!

Caesar had weaknesses galore,
He reveled and he drank and swore;
He had his foibles such as these are,
But—weaknesses did not make Caesar!

Napoleon was given to
Doing some things he shouldn't do;
These were his weak and phony part—
They did not make him Bonaparte!

Washington, too, it's plain to see,
Had all the faults of you and me;
But when all this is said and done,
They didn't make him Washington!

So let "de bunkers" do their worst—
When all their stories are rehearsed,
They only serve to prove afresh
The Spirit's mightier than the Flesh!

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

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All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent to THE CHAIRMAN OF THE PUBLICATION COMMITTEE (address above), Newark, N. J.

JANUARY JOURNAL IN DEMAND

We feel sure that many members of the Medical Society of New Jersey will be pleased to learn of a demand, *from outside the State,* for copies of the January Journal, reaching a figure for which we were entirely unprepared.

When gathering material for that issue of the Journal, we had planned to make it a document of importance and of value to all members of this organization; and, especially valuable to those of our members who would not have ready access to much, if any, of the information there-in contained. As it went forth from the publication office we hoped, naturally, that our purpose had been satisfactorily accomplished; and, of that, we soon were assured through kindly expressions of appreciation received from a goodly number of members. But, the reception accorded to that issue of the Journal in other parts of the country, has been both gratifying and surprizing. The Editor purchased 20 copies for presentation to personal friends, but had not dreamed of a sales demand from outside sources.

We felt highly complimented when the first request from another State arrived—asking for 12 copies, and enclosing a check for $3.60—and that pre-paid order was forwarded promptly to the Chairman of the Publication Committee, for fulfilment. Then followed a series of inquiries as to the possibility of procuring extra copies and requests for information as to the cost of a given number of copies, varying from 10 to 100, until the total number asked for, sold, and either specifically or tentatively ordered, is approximately 500 copies.

Unfortunately, it was possible to supply only a small fraction of that number before the Chairman informed us that there were "no further copies available". It is in consequence of this state of affairs, that we are saying: If any member who has no further use for his copy of the January Journal will send it to the Editor's office, in Atlantic City, we will take pleasure in passing it along—*gratis,* of course—to some other member of the profession who has expressed the desire to secure a copy.

THE JOURNAL'S PRESENT PROGRAM

Our County Society Officers having responded so satisfactorily to a request for assistance, by directing attention to the January Journal, we called on them again, with the request that they advise their constituents to be on the look-out for the March Journal carrying another batch of interesting reading matter. We doubt not that our message has already been delivered in some counties, and it is, in consequence, with sincere regret that we find it necessary to ask your indulgence and to explain that it proved to be impossible to procure in such a brief period of time all of the information desired, and some that was essential, for the project we had in mind. So, craving your pardon for this, really unavoidable, delay we renew—but, for the April Journal—our promise to submit a further budget of information pertaining to the so-called Wilbur Committee, and Lowell Commission, Reports.

Special Article

CENTENARY OF THE BRITISH MEDICAL ASSOCIATION HELD IN LONDON, WITH A SUNDAY VISIT TO WORCESTER, JULY 21-30, 1932

Henry O. Reik, M.D., F.A.C.S.,
Atlantic City, N. J.

On a delightful evening in May 1932, peacefully and comfortably ensconced in the "Editor's easy chair" at the close of a happy day in celebration of another of those recurring (now all-too-rapidly) personal birthday anniversaries, we were surprised by the receipt of a telegram from Dr. Olin West, Secretary and General Manager of the American Medical Association, containing the following interesting message and appropriate birthday presentation: "Dr. E. H. Cary, President American Medical Association, has officially designated you to serve as a representative of the medical profession of the United States, and as an Official Delegate from this Association to the Centennial Celebration of the British Medical Association. Can you accept?" Well, yes, we *could,* and, after due deliberation, we *did* accept, though it meant complete disruption of previously well-laid plans for a restful vacation in the Rocky Mountains, with special emphasis upon a return visit to Glacier National Park, and, possibly, also to Mt. Ranier.

Knowing from past experiences something about the manner in which such affairs are conducted in England and on the European Continent, with how much more of "pomp and circumstance" than in this country, we were prepared for a picture in striking contrast to what might happen here on such an occasion. But, even so, our expectations were far surpassed by the actualities; and we have dared to think that some of you might like to hear about the unusual features of that celebration, and that still others would be entertained, at least, by an account of some of the functions.

By fortunate fore-thought, we wrote immediately to the Assistant Secretary, whose acquaintance we had made on a former sojourn in London, asking for full information and whatever personal advice he might be willing to give as to what would be required or expected of a Delegate and how one should dress and comport himself during those festive days and nights. It was well that we did ask for guidance for, otherwise, we might have performed the act of self-exclusion from the most important events. There was, for instance, rigid enforcement of the announced requirement that all participants in the public functions—Delegates as well as Members—must wear academic costume, and, on the occasion when the President of the Association delivered his Address, an afternoon affair in Queen's Hall—one of London's largest public meeting places—nobody not properly gowned and capped was permitted to take his assigned place on the platform. And, it must have been a pleasing sight to those in the audience.

Imagine, if you can, several hundred members of the Association and its Affiliates throughout the British Empire, and perhaps a hundred Official Delegates from Foreign Countries, every one of them wearing the gown, hood and cap of his Alma Mater—recalling the gorgeous gowns of Oxford, Cambridge and Edinburgh, with their brilliant colors, crimson and scarlet, and contrasting ermine trimming—not to mention several Continental Universities whose insignia are equally brilliant—and you share with us a remarkable picture. In the central seat of the front row of that group, whose seating was of semicircular form and about 10 rows deep, was the President, Lord Dawson of Penn, flanked on the right by the Past-President, and on the left by the President-Elect; and further on either side by dignitaries of the Association and of the Empire. The ceremony was one of impressive character, and even so small a matter as the transference of the badge of office from the retiring to the coming President, was performed with such dignity and such emphasis upon the carefully selected words, as to give the procedure a distinctive meaning. We remembered, just at that moment, having heard a colleague say, at one of our Tri-State Conferences, that "the people no longer treat members of the medical profession with the respect accorded them in former times", and we could not help comparing the scene before us with a similar event at home—professional *dignity* contrasted with *democratic* conduct—and concluding that the profession probably receives at any given place just about that degree of respect which it commands by its own behavior, and—if the assumption that it has suffered a loss be true—the road back to complete respect is open and clear.

We will postpone until later an attempt to describe other functions in which we participated during the week, in order to give here an abstract of the Presidential Address, as follows:

The President's Address

ONE HUNDRED YEARS AND AFTER

by

The Right Honorable Lord Dawson of Penn, P.C., G.C.V.O., K.C.B., D.C.L., LL.D., M.D., D.Sc., P.R.C.P.*

Historic Background

Our art has a background of history rich beyond compare. There appears, through the twilight of history in Egypt 50 centuries ago, an art of healing mature in form, and with it a leader of men. Imhotep was born about 3000 B. C. and belonged to the time of King Zoser of the Third Dynasty. Great in learning and achievement, he was statesman, sage, priest, physician, architect, and astronomer. As priest and physician, he founded an art of medicine which occupied a prominent place in the polity of Egypt through the succeeding centuries, became merged with the medicine of Greece, and influenced the thought and practice of medicine during the early centuries of the Christian era.

This cult of Imhotep was beneficent in intention and brought to the people healing, support, and solace; but with the lapse of time the ivy outgrew and obscured the tree, and the ritual of shrines and temples eclipsed medical knowledge, and the latter from 1000 B. C. onward lapsed into stillness. Thus the art of medicine which ushered in the dawn of Egyptian greatness preceded it into the shadows, and in result but little ascertained truth floated down the stream of time during those many centuries. None the less, Imhotep the Physician gave inspiration and direction to the march of a people and was elevated to Demigod in 2850 B. C. and to a full Deity in 525 B. C., by which time the Greek learning was gathering influence and the cults of Imhotep and Asclepios became henceforth blended.

I pass to a nearer though greater background—the wonderful age of Pericles which gave the world Hippocrates. In the teaching of Hippocrates mythology was put aside, the supernatural in medicine was rejected, and the observation of disease, objective examination, and the importance of prognosis were the outstanding features. To this day we not only follow his methods but treasure his wisdom.

In the Christian era, alas! there was retrogression; and the growing power of Christianity, although fostering a spirit of service, delayed rather than promoted medical progress. The natural origin of disease did not find acceptance, and the devitalizing magic of the Egyptians returned in no less force because of its altered guise. And the opposition of Christianity to scientific progress for the most part continued, though with diminishing repression, till later days. At the same time it is only fair to say that the Church took a prominent interest in the cure of the sick, and that some of its priests, with the hesitating consent of their Superiors, practiced the art of medicine.

Having then done obeisance to Imhotep and Hippocrates and other early masters in our art, let me pass to the consideration of the hundred years it is our purpose to celebrate.

This address does not envisage a recital, still less a description of discovery. It rather seeks to consider the directions along which knowledge has grown during the century under review and the trends of thought and action which have thereby resulted. How are the problems of the practice of medicine being modified on the one hand by this advance of knowledge and on the other by the rapid changes in material civilization? What is the rôle of medicine in that statesmanship which aims at the health and welfare of the people? I have tried to keep in mind that I have the honor of addressing not only doctors but the public. I need the indulgence of both.

Medical Problems of the Early Years

The opening of the period found medicine without as yet the guidance of either physical or biological science and at the same time faced with problems resulting from profound political and social changes. Sir Charles Hastings founded this Association in the year of the great Reform Bill at a time when the demands of the industrial age were forcing masses of the populations into towns unready to receive them. The result was misery, ill-health, and discontent. To consider the then conditions of life will make clear the disability and disease with which the medical profession had to strive. Houses already overcrowded were deprived of light by the operation of the Window Tax imposed on every extra window in a house which indulged in "1 over the 8" permitted. The smaller dwellings were commonly without a supply of water, which was distributed by means of standpipes (1 to some 15 or more houses), out of which water ran for an hour or less 3 or more times in a week. The inhabitants carried the water or brought it from carts and stored it in vessels. Small wonder that they washed neither their houses nor their persons. There was a saying that only on entering the world and again on leaving it was a citizen well washed.

Till those days houses were either undrained

*P.C., Private Councilor. G.C.V.O., Grand Commander of the Victorian Order. K.C.B., Knight Commander of the Bath. M.D., Doctor of Medicine. D.Sc., Doctor of Sciences. D.C.L., Doctor of Civil Laws. LL.D., Doctor of Laws. P.R.C.P., President, Royal College of Physicians.

or connected with cesspools; and sewers were built only to carry off water from the land and empty it into rivers. As the population rapidly increased, the honeycombs of cesspools became inadequate and overflowed into and saturated the soil. House drainage was then for the first time connected to the sewers, with the result that the rivers became large open cesspools, and if these rivers ran through towns the effects were disastrous. In London, for instance, the Serpentine became an open sewer which drained Kilburn, Paddington, and Bayswater. Infective diseases ravaged the land. One is reminded of Artistotle's dictum:

"The greatest influence upon health is exerted by those things which we most freely and frequently require for our existence, and this is especially true of water and air."

During the year of this Association's birth the country was in the throes of a cholera epidemic from which the number of deaths in England and Wales exceeded 50,000. In 1848 cholera was responsible for 5275 deaths in London—a mortality of nearly 48% of the cases. Typhoid and typhus and diphtheria were ever-present perils. The infection of wounds, erysipelas, and gangrene made the surgical wards of hospitals sources of danger.

There was still planted in men's minds the idea that epidemic diseases were visitations beyond our ken and control and having origin in disturbances of earth or sky or in the minds of gods—habits of thought little different from those belonging to the age of Egyptian medicine. A break from this tradition of helplessness came with growing confidence in vaccination. In the first 2 years of Queen Victoria's reign there were 30,000 deaths from smallpox in England and Wales, apart from numberless people disabled or disfigured. In 1840 optional vaccination was provided by law, and by 1853 the mortality had been reduced 50%. In 1853 vaccination of infants was made compulsory, and by 1863 the mortality had been reduced 30% further.

The attitude of authority toward epidemics is shown by the following minute:

"November 11, 1831.—The Board agreed to take precautions against Cholera, along with the Town Trustees, Church Burgesses, Magistrates, Surveyors of Highways, Church Wardens and Overseers."

Another minute throws light on the standard of nursing:

"January 5, 1849.—Resolved that an advertisement be inserted in each of the papers tomorrow for a nurse who can read and write, or at least read writing, and must produce good recommendations as to character and ability."

The Ferment of New Knowledge

Altogether for the sick and disabled and for those who tended them it was a struggle in the darkness with little to lighten the pathway till the eighties of last century. But during the waiting years great minds were working—that of Virchow, for example, in cellular pathology; of Claude Bernard in physiology; of Bright in medicine; Chadwick in sanitation—and in 1859 the world of thought became aglow with the publication of the *Origin of Species,* the first edition of which was sold out on the day of publication.

In 1857, Pasteur presented to the Academy of Sciences his paper on "Alcoholic Fermentation", in which he showed that the process was a vital one and due to invasion by living organisms. Little can he have thought that this discovery was the dawn of an era. During the early sixties he demonstrated the presence of bacteria in air, dust, and water, the power of heat to destroy them, and the sterility of media protected from their contamination.

At this time there went to Glasgow Joseph Lister. Seized with the meaning of Pasteur's experiments, there came to him the idea that germs from outside caused the decomposition of wounds. After 5 years Lister had solved the problem of wound infection and modern surgery was born. Pasteur and Lister were the world's deliverers. They had followed the injunction of Harvey to search out and study the secrets of Nature by experiment.

From 1865, onward for 6 years, Pasteur turned his attention to silkworm disease, and this, like other of his researches, had the stimulus of direct public purpose, for the preventive measures he devised saved that industry. There were 2 diseases each of which was due to a specific infection. When experimentally transmitted from worm to worm in series the period of incubation of an infection was shortened and the virulence increased and the worms showed variations in susceptibility and resistance. Here light was thrown on the problem of infection. Further landmarks on the road of knowledge were afforded by Pasteur's researches into epidemic chicken cholera. He found that cultures of the organism lost their strength with age, and that by inoculating fowls with these attenuated cultures he conferred on them immunity against chicken cholera—in short, he had laid the foundation of preventive vaccination. He further discovered that this microörganism which was virulent in its effects on fowls was mild in guinea-pigs—that whereas fowls were very ill and died, the disease produced local abscesses but not illness in guinea-pigs. Thus the conception of the carrier.

Next anthrax; and now on the stage beside

Pasteur comes Koch—the one a chemist and the other a country doctor. Koch first and Pasteur later demonstrated the constant presence of germs in the blood of animals suffering from anthrax: they grew those germs on suitable media outside the body through several generations and reproduced the disease in animals from the last sub-culture. There followed the demonstration of preventive inoculation against anthrax in dramatic manner; 25 sheep were vaccinated by attenuated cultures of anthrax and 25 controls were left unvaccinated. Subsequently the whole of the 50 sheep were inoculated with a virulent culture of anthrax. The vaccinated sheep all recovered and the non-vaccinated all died.

The climax of Pasteur's discoveries was the cause and prevention of rabies. Here was a dread disease, comparatively rare, affecting the nervous system, and with a long incubation of weeks or even months. By changing the seat of inoculation from the skin to the surface of the brain he shortened the period of incubations from months to weeks. By passing the disease from rabbit to rabbit in series he raised the virulence of the infection and shortened the inoculation period to one week. By keeping the spinal cords of mortally infected rabbits in dry air he found the virus in them became attenuated proportionately to the length of such preservation. By inoculating dogs from these rabbit cords, in doses of increasing specific strength, these dogs were found to be protected. Then came a dramatic happening—a boy from Lorraine, bitten badly by a mad dog, was given injections of increasing strength for 9 days and the protective virus with its short period of incubation got ahead of the mad dog virus with its longer incubation period. The boy was saved and thus was established the preventive treatment of hydrophobia for the benefit of the world.



The President, Lord Dawson of Penn, is third from the left in front line; the Secretary, Dr. Cox, is at right end in back row, leaning against the pillar.

This culminating achievement brings us into the eighties of last century. Pasteur and Lister had given men's minds a new impulse—their thought a new direction—the world a new learning—the beginning of it all had been Pasteur's study of the law of fermentation. It is interesting to recall that this new learning had been rendered possible by the completion of the compound microscope by Lister's father in 1830. Yet another association: this year is the tercentenary of the birth of Leeuwenhoek, creator of the first microscope; and the first learned body to recognize this important advance was the Royal Society of this country.

Then the harvest—in 1882 Koch demonstrated the tubercle bacillus—an event great in itself and in consequence. There followed the discovery in rapid succession of the causal germs of typhoid, diphtheria, cholera, tetanus,* plague, pneumonia, gonorrhea. Nor must we forget the discovery of the causal germ of Mediterranean fever by Bruce. The position of bacteriology had become commanding and caused the dry bones of pathology to live.

Beside Pasteur stands the figure of Manson, the Father of Tropical Medicine. Alone and unaided at Amoy in 1877 he demonstrated the periodicity of filariae in the blood (first discovered by Timothy Rees), their numbers increasing till midnight and disappearing by noon. He was the first, in 1879, to perceive the rôle of the blood-sucking insect. With only meager apparatus and after months of work he ultimately succeeded in tracing the filaria through the stomach wall of the mosquito, and thence into its thoracic muscles, and he observed that during its passage the little parasite increased enormously in size; it developed a mouth, an alimentary canal, and other organs, and he says that "manifestly it was on the road to a new human host". Listen to his prophetic words in a letter to Cobbold in June 1879—and please note these dates:

"This is a striking and most suggestive fact, and in connexion with it one might be tempted to speculate on the causes of the periodicity of malarial fevers. It is marvellous how nature has adapted the habits of the filariae to those of the mosquito. The embryos are in the blood just at the time the mosquito selects for feeding."

The malarial parasite was in fact demonstrated a year later (1880) by Laveran—a young Frenchman—but this discovery fell upon stony ground. Even in 1893 Ross, writing in the *Indian Medical Gazette,* speaks of "the supposed hematozoon". Then, in 1897, Manson demonstrated to Ross, in London, the malarial parasite and its crescents. As a result "Ross not only went in with the few who received Manson's theory with joy", but became the convinced adherent who voluntarily undertook the labours of demonstrating its fundamental truth and in the event gave it the perfect precision it had hitherto lacked. Years later, in 1909, when vacating the presidential chair of the Society of Tropical Medicine, Manson, with characteristic largeness of heart, claimed credit for himself "not so much for having formulated the mosquito-malaria theory as for having discovered Ronald Ross".

Following Manson's vision of insect-borne diseases the road of discovery opened out. Bruce was the first to demonstrate the transmission by an insect of a protozoal disease—namely, the tsetse fly as the conveyor of nagana disease in cattle; Ross demonstrated the transmission of malaria by the mosquito; and by 1900 yellow fever, one of the world's worst scourges, had been shown beyond peradventure, by an American Army Medical Commission in Cuba, to be similarly conveyed. David Bruce correlated the tsetse fly with sleeping sickness: the cause and transmission of amebic dysentery became known, and in 1905 came the discovery of the spirochete of syphilis by Schaudinn.

The knowledge of bacterial and protozoal diseases achieved in the closing years of the nineteenth century was soon to be put to valuable test. Pestilence had played a large part in defeating past attempts to build the Panama Canal, so when the United States undertook that project in 1904 it first established a Health Administration under General Gorgas. In 2 years the mortality among the workers was reduced by two-thirds. Yellow fever had been banished and dysentery was under control; altogether a fine example of statesmanship directed by medical knowledge.

The Acceptance of New Truths

It is interesting to reflect on the varying degrees of difficulty which new truths have to encounter. In retrospect one wonders at the want of receptiveness in men's minds. That the discovery of the anthrax bacillus in the blood of patients roused men's minds while the previous discoveries in the blood of the malarial parasite (1880) and of the spirillum in relapsing fever (1873) were but little noticed, is an instance of how the implantation of truth depends not only on its discovery but on the readiness of men's minds to receive it.

The history of anesthesia affords a striking example of how long truth may remain unheeded. The anesthetic properties of nitrous oxide were described by Humphry Davy in 1800 and those of ether by Faraday in 1818. Hickman tried in both England and France, in the years 1824 to 1828, to secure consideration for anesthesia as a practice. Yet despite repeated stimuli the imagination of the medical world remained untouched. To the year 1844 does not belong *the discovery* of anesthesia but its *acceptance*—nearly half a century after the birth of the idea.

On the other hand, it cannot be said that the acceptance of the infective theory of disease and its meanings lingered unduly, and this was no doubt due in large measure to the qualities of character of its apostles. Pasteur had to dissolve long-established belief and he did it by a notable quality of appeal. From

*To Kitasato, in 1889, we are indebted for obtaining the tetanus bacillus in pure culture, and with Behring for antitetanic serum.

his genius came a revelation which time is still unfolding. Lister had not only to win men's minds but conquer the fixed habits of a craft and he did it with a patience only equalled by his persistence. Nevertheless, a generation of disciples bred in its methods was needed to bring his teaching to fruition. Even he from the heights of Pisgah saw but dimly the promised land—neither encompassing the surgery nor performing the operations which his own discoveries had rendered possible. The beauty of Lister's character is illustrated in a letter he wrote to Pasteur in 1874:

"Allow me to take this opportunity to tender you my most cordial thanks for having by your brilliant researches demonstrated to me the truth of the germ theory of putrefaction, and thus furnished me with the principle upon which alone the antiseptic system can be carried out. Should you at any time visit Edinburgh, it would, I believe, give you sincere gratification to see at our hospitals how largely mankind is being benefited by your labours."

Thus, with the early years of this century the craft of surgery, never lacking in technical skill, was set free and with results fruitful of great benefit to mankind. It has lately been stated with authority* that the craft of surgery had "almost reached the end of its progress along the lines which so far it has followed", that "the full fruits of Lister's work have now been garnered", and that with operations now carried out upon every organ in the body little further success can be expected. This gives me to wonder and to think. Surely surgery has not reached so gloomy a finality. "Life is short but Art is long." Listerism, which freed surgery of its chains, is surely a great permanent possession which conditions all progress but without determining the nature or limit of that progress.

On the other hand, has not the extension of the field of surgery been determined by the growth of knowledge derived from physiology and pathology and by improvements in technic? The researches of Pavlov gave inspiration to the surgery of the alimentary tract, and radiology and chemistry have been increasingly reliable guides. The change is not in facts but in habits of thought. At the beginning of this century, when surgery took possession of the freedom Lister bestowed upon it, there was a bound ahead and with it an exuberance of craft, which was sometimes forgetful of physiology and wider clinical considerations. That detachment has passed and surgery has come back into the fold of medical knowledge. And has not the craft of surgery large fields yet to conquer? There come to my mind the thorax, the arteries, the nervous system, and



Procession leaving the Cathedral at Worcester, the city in which the Association had its origin under guidance of Sir Charles Hastings.

*Romanes lecture (1932) by Lord Moynihan. A similar view was expressed by Professor Erichsen in his introductory address at University College, London, in 1873.

the ductless glands, as examples which are on the threshold of their possibilities whether of purpose or technic.

The Art of Healing

The art of medicine embraces the understanding of illness no less than the morbid process, and if the physical and biological sciences are given a too exclusive attention they are apt to give to medical thought a too pronounced objectivity. We welcome their guidance and even their chastening but we have to be naturalists as well; we need to take count of the whole man.

What of personality and its infinite variety? What of environment? In these days, when diseases of invasion are receding and diseases of stress loom larger, both these factors receive accentuated importance. A man's physical and mental make-up—his inborn trends—play no small part in the clinical picture he presents. To take simple examples—in similar circumstances of stress one type of man will get hyperchlorhydria, hypertonic stomach, and it may be, duodenal ulcer; while another man gets hypochlorhydria and an atonic stomach. Some people are born with achlorhydria and its attendant disadvantages. Again, one type of man develops high blood pressure, while another type in like conditions develops low blood pressure. And so with the mind—its make-up, both inherited and acquired, may color or even confuse the picture presented by a physical illness. The latter may release some buried or suppressed emotional experience which in its turn will produce further physical reactions. To effect a cure both aspects of the illness must be studied. This wider comprehension demanded of medicine may be set forth by an illustration:

Given a business man—efficient, impressionable, courageous; his parents brought him up in the cold shadow of virtue and not in the sunshine of the understanding heart, so he had learned repression, not self-expression. He gets over-worked, loses confidence in himself, doubts the rightness of his calculations and decisions, suffers self-depreciation, anxiety, insomnia; and all this hidden behind an outward appearance of carrying on cheerfully. At this point the stress may take effect in one of several directions. For instance, it may knock out the nervous system regulating the intestine: the diagnosis is "colitis"; he is satisfied—"Here is the cause of my troubles—a microbe in my intestine." If the microbe is not crushed very soon and the illness lingers, he is told he is "nervy"; this causes a pang of self-reproach; he retires into his shell, his colitis gets worse, and he drags on until, we hope, he meets a doctor with a more comprehensive outlook.

Pervading these problems there is a fundamental error of thought—namely, that disturbances of your mind are under your control and are therefore your fault, whereas disturbances of your body are not under your control and are therefore your misfortune. This false doctrine of control, and all the perversions of the doctrine of free will with which it has long been entangled, are responsible for much faulty thinking and human suffering. Self-control can be bought too dearly or sought where it ill belongs.

As to treatment of these complex patients. Apart from remedies which are specific and those which assuage pain and assist relaxation and sleep, efficient treatment lies in comprehensive diagnosis. It is sometimes only necessary to explain an illness, for the patient to cure himself. Let the doctor understand the component parts of the picture and explain faulty trends of thought and feeling and their relation to bodily function. Thus restoration of perspective and reassurance will follow and the patient will be put on the road toward health. True, the faults and errors may be too ingrained for remedy by a single readjustment; then the treatment becomes educative, and needs the discerning mind-reasoning which is persuasive, and those further gifts of the teacher—the power to give from himself understanding and confidence, and this the more effectively because unwittingly. It is far easier to prescribe medicine than to give the patient healing.

Kinship Between Medicine and Education

This increasing kinship between medicine and education leads to further reflections. Our public medical services and the various voluntary agencies which have the same objective should be judged even more by what they teach than by what they provide. The infant and child welfare clinics and the school medical services respond to this test. They have given parents not only help but vision of better things and have stimulated individual effort. And does not medicine teach this to be the touchstone of sound state-craft? Health, like healing, comes in last resort from within. Stimulation and assistance from without—yes; but such must not replace or outpace the integrating process within. If they do, there follows a negative phase of inertia and a paralysis of that individual endeavor on which depends the onward march of the organism. Has not latter-day statesmanship fallen into this error?

Ways and Means

There is now alike ability and desire to investigate illness in its early or potential stage, and this aim of constructive health has increas-

ing support from the public. We see it on the preventive side in the work of Industrial Health Board by means of which the misfitting of the worker to his task, with its tale of ill-health and unhappiness, is avoided or ameliorated; stress of body and mind and the balance between effort and relaxation are studied, to the advantage of the work and the contentment of the worker. Many large firms have welfare organizations on similar lines.

Persisting deviations from fitness require investigation. Hospitals and clinics will be needed for every class of citizens. There investigations can be made and results marshalled and at less cost. Care will need to be taken that general practitioners do not become separated from their patients when the latter enter hospitals, for such would damage professional efficiency, to the disadvantage of the public.

When the nature of the defects is disclosed the mere giving of medicines will often accomplish but little. What the patient wants is regimen and reëducation in methods of living; treatment, it may be by diet, physicotherapy, and relaxation, under controlled observation. Such treatment or education of the man and his tissues might take several weeks, and in most instances it would be advantageous for such patients to continue their ordinary avocations. We need a new type of institution—distinct from hospital provision—namely, a Health Hostel. Examples flow from any physician's experience. Over-weight—the man of 40 getting a fat body and a fat head, who avows himself a small eater yet is clogged with his own metabolic products; the man becoming set about the neck and waist, who turns his body slowly rather than his head and eyes quickly, or who is bluish and breathless, losing his rib movements and wants to "stay put". Then the various gastro-intestinal victims who need to be taught how to eat, how to digest, and to regulate their bowels, and perhaps to be cured of their "conscious abdomens". Then again the patient in the early diabetic stage where not only himself but his wife needs instruction in food calories and cooking, and it may be in the administration of insulin. All such and many more need for a space a designed environment; they require education but under the conditions of their working life. Such institutions must have a kitchen under a trained dietitian, and a physiotherapeutic department; skilled control, but no cults or fads. It would prevent disease in untold measure and would be self-supporting and even profitable. The cost to the individual might, where necessary, be defrayed out of that comprehensive sickness insurance scheme which we wait long and wearily for the vision and constructive ability of the insurance companies to provide.

Education in Health

The good of the people demands education in matter of health. Would it not be possible for the medical faculty of a university to include among its functions the provision of approved health lectures when such are demanded by the districts within the area of its influence? In this way sound educational standards would be maintained—fads and fancies avoided. The objective of such teaching should be a knowledge of health with only incidental or illustrative reference to disease. The result would be great saving of illness and therefore in a few years of expense. Medical insurance costs employers, employed, and the state £36,000,000 a year. Not the least advantage of education would be to dissipate belief in the magical with its false gods, and to inculcate belief in the reign of law and its close pursuance as the only way:

> 'Spells? Mistrust them.
> Mind is the spell which governs earth and heaven."

Research

Nature will not yield her secrets on demand, nor can discovery be bought. You can decide a path of inquiry but neither its end nor its exact direction. Our aim should be to secure the men—to enable those possessing the ability, and while still young, to live free of anxiety so as to seek out the secrets of Nature. The medical sciences are so embracing that their pursuit yields results beyond those of direct human application. I need only instance the study of genetics or that of virus disease. Take foot-and-mouth disease, and diseases of potatoes and bananas. These concern not only our food but by their ravages involve the loss of vast sums of money.

In this country the quest for new knowledge is to be found in all and varied quarters, and a rich harvest is being gathered. The Medical Research Council is doing a great service in supporting and directing efforts wheresoever they come, and it maintains contacts between workers and between the institutions to which they belong. There is, however, need for further coördination among bodies which represent varied aspects of medical knowledge, such as the basic sciences, medicine, surgery, obstetrics, education, and administration. It is a reproach against our profession that we do not establish means of giving collective advice when the art of government depends increasingly on our knowledge. Gods on Olympus, however wise, cannot in detachment represent collective authority. Corporate advice could

be forthcoming only if there existed the means for its expression. To the hackneyed saying that "doctors always differ", let me reply that the vain repetition of error does not convert it into truth. In fact, there is no sphere of learning in which consensus of opinion on matters of importance is so forthcoming as in that of medicine. Contrast with it for example economics or politics, and recall the confusion of tongues over the cure of our post-war afflictions—and it is an intellectual exercise and even a treat to hear one court of law upset the decision of another.

Conclusion

If we look back, what a panorama presents itself during the life of this Association; and never was there greater promise that the advancing front of knowledge will "make one music as before, but vaster".

Pursuit of knowledge in the medical sciences not only brings results prolific of benefit to mankind, maybe by adding to life's quality or lightening the burden of suffering, but its very pursuit makes doctors of every nationality and clime into comrades who, animated by the same ideals, think and work together—the gold of endeavor without the alloy of conflict. Does not this distinguished gathering of guests, whom I am so proud and happy in your name to welcome, bear witness? Be it remembered, there burns in our temple not only the lamp of reason but the lamp of service. These together betoken the qualities of wisdom and the understanding heart, and that desire to know "who is my neighbor" which gives to life its savor and to humanity its hope and purpose.

(To be continued.)

Medical Ethics

RELINQUISHING PATIENT TO REGULAR ATTENDANT

John Hammond Bradshaw, M.D., F.A.C.S.,
Orange, N. J.

"When a physician is called to a patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter." Prin. Med. Ethics, A. M. A., Sec. 8, p. 17.

Anyone with the brains of a rabbit, reading the above article of ethics, would think that it covered all the ground of the subject, and that little more need be said. Is the subject not put in such a concise way that it requires no further elucidation or qualifications to make it entirely understandable and even final? But, unfortunately, now enters the patient. And with the patient's own interests (did we say "selfishness"?), all of which have made him not a little irritable by reason of his illness, he often is unreasonable enough to cry out—"to hell with medical ethics".

The patient pays (or, rather, the doctor hopes he will pay) his good hard cash for medical treatment. The patient, furthermore, resents the idea that he is the exclusive personal property of any doctor. Should we not always remember that when a man's body is sick, his mind is likely to suffer from the complaint? We know only too well that his whole line of treatment, since he has been ill, has encouraged the idea that whenever possible his every whim should be gratified. Not only his devoted family, but his devoted trained nurse (and we know how devoted she can be) have encouraged him in this idea. He (the patient) is the sufferer, and suffering is the one thing the whole world wants to relieve.

Next to assuaging his pain comes the wish to make him happy—that is, as happy as his wounded body and spirit will permit. This, indeed, is what his entire family, his trained nurse and even his doctor aim to achieve.

We grant you that the doctor's lot is not an easy one. He does not always slumber on a bed of roses. First of all, he must cure the patient—by removal of the disease. All other considerations should be secondary. Of course he must satisfy the patient. One would think that if he fulfilled these duties, that would be sufficient. It is not! Next come the relatives! Today, even with all our advanced thinking, we cannot do as did that noted Russian specialist who, before he made a call, demanded that "all dogs and relatives be tied up". If one thinks, now-a-days, that the *dear relatives* can be ignored, he is bound for a sudden and rather harsh awakening. The relatives always seem to take a kindly but rather unusual (unkindly?) interest in the patient's doctor. When the bad days of the illness come—as they are certain to come—the sweet relatives are quite sure that "something should be done!" Does not the harassed physician in charge feel the same way? But why rub it in?

The devoted doctor is now met at the door (he has hardly got out of his automobile) by one of the mother-in-laws, a cousin, or an aunt, and he is asked, in that gasping manner we know so well, if he will not "step just a minute" into that interrogatory chamber for "just a word". Here he is subjected to "the third degree". God help the poor man if now he makes a slip. Unfortunately, just now the "bedside manner" and "voice with a smile" are not worth a damn.

Hostility, doubt, disfavor toward and unbelief in the attending physician, as shown only too often by the relatives of the sick, are

poor psychology. They dampen the physician's optimistic hopes and confidence in his own ability or skill. They even work a poor psychology for the success of his treatment. The physician, in spite of himself, is at an immediate disadvantage.

Now, does all this bring to an end the worries or distresses of the attending physician? One would think it enough. But the doctor is a long suffering animal. During his younger days, he (innocently) dreamed that he was "doing the work of the Master". In his later days (believe it or not), after putting financial emolument in the background, he works in a sincere attempt to relieve pain and distress. Does he not devote all his thought, ability and activity to returning the disabled to a work-a-day world?

But we have forgotten the neighbors! Now the neighbors are important. They not only take a lively interest in the personal biography of their friends, but seek to guide them into paths of righteousness and to save them from the error of their ways. Of course, we, as physicians, want the neighbors to admire our work. We want them to like it to such an extent that when they themselves are ill, they will send for us as their first thought for "aid to the sick". Unfortunately, neighbors have their own pet doctors, and it is natural that they should sing the praises of these doctors in the seats of the mighty. A little leaven will leaven the whole loaf. The neighbor often has that particle of leaven up his sleeve. If you are on the "outs" with that neighbor, all your skill and devotion are, often, simply thrown away. A little suggestion like this—"Your doctor seems to have lost interest in your case"—or—"*my* doctor never lost a case suffering from your complaint"—but, why multiply the examples? Have we not heard them all?

You (if you have had the patience to read this far) will exclaim: What has all this to do with your text? It all has a tremendous relevancy to our personal relations and ethics as friends and fellow practitioners. It shows how and why we must stand together, and while not asking us to be our brother's keeper, it will keep us from letting our brother lose his grip. Osler truly said: "The joke is on the other fellow today, but as sure as fate it will be on you tomorrow." It seems trite to remark, but we can help our brother most—by doing nothing we would not want him to do to us.

So, can we not all heartily subscribe to that article, taken from among the A. M. A. Principles of Medical Ethics, which heads this modest paper?

In Lighter Vein

Men of Shears Shed Some Tears

"I'm worried", said the barber,
"I have lost my merry song,
So many people shave themselves
I barely scrape along."
—Boston Transcript.

"I'm worried", said the tailor,
"I could break down and bawl,
If this nudist cult keeps spreading
I'll make no clothes at all."
—Buffalo News.

No Lather in It

Barber—"Haven't I shaved you before, sir?"
Customer—"No, I got that scar in France."—Christian Science Monitor.

Round 'n Round 'n Round

Mr. Peters—"At last we're out of debt."
Mrs. Peters—"Oh, thank goodness! Now I can get credit again."—Answers.

Prestissimo

Neighbor—"Where's your brother, Freddie?"
Freddie—"Aw, he's in the house playing a duet. I finished my part first."—Pathfinder.

Mass Ablutions

Dumb Dora—"I don't see how football players ever get clean!"
Ditto—"Silly, what do you suppose the scrub teams are for?"—Annapolis Log.

Crowd with a Kick

Political Speaker—"I'm pleased to see such a dense crowd here tonight."
Voice—"Don't be too pleased. We ain't all dense."—Baltimore Southern Methodist.

Fellow Feeling

Race-horses do not eat the day before the race, according to a magazine article. And often we do not eat for days after the race.—Atlanta Constitution.

Humbled Aristocracy

First Hobo (surveying stream of pleasure-seekers)—"I 'ates 'olidays. Makes yer feel common when nobody ain't workin'."—London Opinion.

Muting the Eats

Princeton is rife with anecdotes of former President Francis Landy Patton, who has just passed his ninetieth milestone in his island refuge, Bermuda. An alumnus remembers how he once dealt with a class who got on his nerves by shelling peanuts while he was lecturing. He said:

"Young gentlemen, I had hoped before I reached this point in the lecture that the visible supply of peanuts would be exhausted. I realize that these lectures to which you are compelled to listen put a great strain upon you, and I have no desire to interfere with your natural right to seek that refreshment which will enable you to bear up under that strain. But I am a somewhat nervous man, and I must admit that the constant popping of peanuts is somewhat disturbing to me. I wish that in the future you would be willing to substitute some less audible means of refreshment, say sponge-cake."—New York Christian Advocate.

Lighthouse Observations

WHAT ABOUT THE ANTIDIPHTHERIA FIGHT? ARE WE SLIPPING BACKWARD?

The New York City Commissioner of Health, Dr. Shirley W. Wynne, says that in the year 1932 diphtheria claimed the lives of 212 children in that city; which is 26 more than in 1931, and the greatest number of diphtheria deaths reported since 1929. Commissioner Wynne emphasized the fact that not one of these 212 infants who died last year should have been permitted to perish of that disease; and, *had the parents of those youngsters heeded the admonitions of the Department of Health, each and all of them—innocent victims—would have been alive and well today.* "The fact that diphtheria immunization will prevent diphtheria", says Dr. Wynne, "is so well known, and immunization is so readily available to all, that *there is no excuse on the part of any parent for permitting a child even to have diphtheria,* much less to die from that cause."

From the very day when Dr. Wynne became Commissioner of Health, in 1928, he has been urging the immunization of children against diphtheria. In 1929 his Diphtheria Prevention Commission began to function, and for 3 years, thanks also to the financial aid of the Milbank Foundation, the Metropolitan Life Insurance Company and others, it was able to conduct an intensive anti-diphtheria campaign. "In 1928, the year before the Commission began to function, there were 10,776 cases of, and 642 deaths from, diphtheria; in 1929, the number of cases fell to 8548 and deaths to 463; in 1930, there were 3794 cases and 198 deaths; the year 1931 showed 3999 cases and 186 deaths (the lowest ever recorded in this city); and 1932 brought 3585 diphtheria patients and 212 deaths. The Commission having completed its demonstration, the work was taken over by the Department of Health in November 1931.

Without any added expense or outside financial aid, the Department of Health continued the anti-diphtheria work and in the 12 months of 1932 recorded the immunization of 166,000 children, 27,931 of whom were immunized by private physicians. That these figures indicate the smallest number of children immunized by private physicians in any single year *was probably due to the economic depression.* In the first year of the antidiphtheria campaign (1929), private physicians immunized 62,538 children; in 1930, they immunized 63,045; and in 1931, slightly less than 3400."

In full recognition of the *depression* factor, however, someone may justly ask whether family physicians have coöperated in continuance of the campaign as fully as they could or should have done? Of course, the Commission could do things which the private physician could not without having his motives questioned; i.e., the insinuation that his urging parents to permit him to immunize the baby is due to self-interest. True as that may be, is it not off-set by other considerations; for instance, in part, at least, by his obligation to protect others in the community against infectious diseases?

From these statistics, and additional figures given in Dr. Wynne's report, one would be justified in drawing the inference that as soon as his Commissioners were withdrawn the number of young children given protective treatment by family physicians began to fall off because the said physicians did not effectively reach as many children. Why? Perhaps they *could not.* As we have no evidence showing how much effort they made, we must not too hastily or severely judge them to have been derelict in respect to performance of duty.

We have utilized this report because it has an important relationship to a condition existing in our own baliwick. In our Journal of September 1932 we directed attention to the fact that a dangerous state of affairs threatened to obliterate the gains made in our state-wide campaign of recent record. As a result of that effort, New Jersey could see the possibility of diphtheria abolition from her territory. Her adult citizens were safe; her school children were practically all immunized; the pre-school age children alone remained to be cared for. The machinery remained in working condition and was delivered into the hands of the family physicians. As everybody knows, the pre-school child—the child between 6 months and 6 years of age—is the all-important factor in the solving of our diphtheria problem. The schools were cleared of that disease, but how long would they remain so? Only until the next term brings in a batch of unprotected children, because: The *5 year old pre-school* child becomes next year the *6 year old school* child. Unless the schools are kept clear, we shall soon have the work to do all over again; and that condition of the schools can be maintained by admission of immunized children only. In that respect, we are slipping already. Indeed, it has already become so marked that, since we started to prepare this item, an official in the State Department of Health has come to us for the specific purpose of requesting that we appeal to our readers to complete the unfinished task entrusted to them by the State Campaign Committee.

We are glad to repeat the appeal presented in the September Journal and we urge all general practitioners to coöperate to the fullest extent until we shall be able to say: We have no diphtheria in New Jersey.

That the desired goal can be reached is proved by last year's experiences in the cities of Newark and Elizabeth. Health Officer Louis J. Richards, in his Annual Report, says: "With only 1 death from diphtheria and none from typhoid, Elizabeth established in 1932 the lowest death rate in the city's history. The single death from diphtheria was 1 among 44 cases of that disease recorded during the year."

For Newark, Dr. Charles V. Craster, the City Health Officer, says in his report: "The results of our persistent campaign for the immunization of all children against diphtheria in the City of Newark are clearly shown in the spectacular way in which deaths from this cause have been reduced. With only 2 deaths due to diphtheria in 1932, we established a rate of 0.4 per 100,000 of the population; the lowest rate from diphtheria ever recorded in this city. In 1931, the rate was 3.7; in 1930, 10.4; and in 1920 was 20 per 100,000. For 15 consecutive months in 1931-1932, there were no deaths recorded from diphtheria in the city of Newark. When we consider the ravages of diphtheria among our child population in past years, the present results seem incredible. In 1895, the death rate from diphtheria was 126.6 per 100,000."

What has been done in Elizabeth and Newark can be done elsewhere and our County and City Antidiphtheria Campaign Committees should—wherever diphtheria still exists—continue or renew their efforts at prevention, and particularly their efforts to secure immunization of all pre-school-age children in their respective districts.

Dr. J. Lynn Mahaffey, Director New Jersey State Board of Health, in a Radio Broadcast recently said that diphtheria prevention work, by means of toxin-antitoxin or toxoid has been carried on so extensively in New Jersey that most parents throughout the state know that their children have been or can be protected against this dangerous disease, and the records show that 500,000 New Jersey children have been given this simple and safe defense. When diphtheria germs were first recognized, 50 years ago, the New Jersey death rate from this disease averaged 10 per 10,000 population. Antitoxin was discovered less than 40 years ago and a great decrease in deaths followed its use, so that by 1900 the death rate had dropped from 10 to 4. Later, toxin-antitoxin and toxoid were perfected, and now we do not wait until the child gets diphtheria and then cure him with antitoxin; we now, by using these preparations, prevent him from becoming sick. This sensible method has been used extensively during the past 5 years. Two years ago, the death rate dropped below 1, and in 1931 it was only 3/10 of 1 per 10,000 population: a decrease of 97% in 40 years. In 1911 there were some 6000 cases of diphtheria in this state; last year there were only 1400.

To witness such a retreat of one of the most cruel diseases afflicting children, is gratifying to public health workers, physicians, and parents alike. But 1400 cases and 100 or more deaths a year is still too large a number to accept without challenge. What can we do to reduce diphtheria still further?

The group of children which is least protected, by nature or by immunization, is composed of children below school age. To parents of such children I say, *provide protection* for them, without delay, by *your family physician*. If for any reason you cannot *afford* to pay for that, consult your Board of Health to learn where your child can receive protective treatment against diphtheria, without cost.

UNIMMUNIZED BABY DIES FROM DIPHTHERIA

If seeking a specific demonstration of what can be accomplished in the direction of complete abolition of diphtheria from a given territory, one could not do better than read the following statement concerning the city of Auburn, New York, published in Commissioner Parran's "Health News" of Feb. 20, 1933, p. 29.

A child, aged 16 months, died from diphtheria on December 20, 1932, in the city of Auburn. A physician had not been called until December 19, which was 5 days after the baby became ill with what was thought to be *a cold*. The child's illness was far advanced but, as should have been done, she was given antitoxin on the day on which the diagnosis of diphtheria was made. The clinical diagnosis was confirmed by laboratory examination of nose and throat cultures.

This child had never received protective injections of toxin-antitoxin or toxoid, though 7 other children in the family had received toxin-antitoxin a year or more previously; in 5, the results of subsequent Schick tests were negative; for the other 2, there is no record of subsequent test of susceptibility.

There was a rumor current that a casual remark had been made at a local clinic to the effect that the death of an infant, who had been ill from an intestinal disorder for a few days prior to receiving toxin-antitoxin and who died from convulsions 3 days thereafter, might have been due to immunization treatment. The rumor had spread quickly with the result that the mother of the 16 months' old child in question, as well as several other mothers in the neighborhood, refused to bring their children for antidiphtheria treatment.

Although the child who died had not been isolated from the other members of the family, presumably because the diagnosis of diphtheria was not made until after medical aid had been called in, none of the other children developed the disease. Throat cultures from several of the other children in the family who had received toxin-antitoxin were positive for diphtheria bacilli but none of them showed clinical symptoms.

This is the first child death from diphtheria to occur in the city of Auburn since January 1928, and the first child case in that city in the past 4 years. For several years, Auburn has been one of the upstate communities in which special effort has been made to protect against diphtheria a high percentage of children under 5 years of age, the age group in which the largest number of deaths from diphtheria occur. And, 51% of its child population under 5 years of age had received 3 doses of toxin-antitoxin or 2 doses of toxoid, as of January 1, 1933, according to records on file in the State Department of Health.

Current Events

MINUTES OF THE WELFARE COMMITTEE MEETING

Trenton, N. J., February 5, 1933

The meeting was called to order by the Chairman, Dr. Schlichter, and the roll call showed members present: Drs. J. G. Coleman, Conaway, Davis, Green, Hagerty, Haggerty, Haussling, Lee, Lippincott, McBride, McMahon, Morrison, Mulford, North, Schlichter, Sherman, Sommer, Tracy and Ulmer; excuses were received from Drs. Berkow, Bloom, Clayton, Costello, Donohoe, Larkey, Londrigan, Meigh, Schauffler and Sewall. Invited guests present: Drs. Newcomb, McGuire, Mahaffey, Quigley; excuse received from Dr. Ely. Guests especially invited for this particular meeting and who were present: Drs. Fischelis, from the New Jersey Pharmaceutical Association; Dr. Steigerwald, from the New Jersey State Dental Association; and Mr. James W. Barrett, City Editor of the New York American.

The report from the Executive Secretary, having been called for by the Chairman, was presented and read by Dr. Reik, as follows:

Report of the Executive Secretary to the Welfare Committee

Mr. Chairman: The *minutes* of the January 8 meeting of this Committee have not as yet been published in the Journal but a mimeographed copy was sent to each member, and that may suffice until the February Journal appears—during this week—unless some member desires to submit now something in the nature of correction or amplification.

Assuming that no revision of the recorded minutes is requested, we wish to announce the fact that shortly after the meeting referred to, the Chairman appointed the following sub-committees, in accordance with resolutions previously adopted:

Committee on National Legislation with reference to Veterans of the World War: Drs. Andrew

F. McBride, Chairman; Lucius F. Donohoe, David B. Allman, J. C. Clayton, and C. A. Brokaw.

Committee to Study and Report upon the Final Report of the Committee on the Costs of Medical Care: Drs. E. S. Sherman, Chairman; Joseph Londrigan, John H. Rowland, Joseph M. Kuder, L. H. Bloom, and S. Rubinow.

On or about January 18, President Lippincott received a telegram from Dr. Cosgrove, saying—in effect—that he had learned of a Bill being prepared for presentation to the General Assembly of 1933, as an amendment to, or a substitute for, the present State Narcotic Law; that it contained some features which he believed to be injurious to the interests of the profession; and he suggested that a special meeting of the Welfare Committee be called to consider the matter and endeavor to secure changes in that Bill before it should reach the Legislature.

The President immediately telephoned to the Executive Secretary and requested that the message be passed along to the Chairman of the Welfare Committee, Dr. Schlichter, to consider and determine what action should be taken; which was done. In addition, we established communication as soon as possible with Dr. Cosgrove and learned more about the details of the measure to which he had referred. In the next conference with the Chairman, the Executive Secretary volunteered to make a personal investigation of the situation and a study of the proposed Bill—since he would have ultimately to make such a study anyhow—and his immediate action might make it possible to avoid an extra meeting and the bringing of 35 members here from all over the state. So, with Dr. Schlichter's approval, Dr. Cosgrove secured an appointment for your Secretary to meet in New York City, Mr. Barrett, the City Editor of the New York American—one of Mr. Hearst's news-papers. Mr. Barrett was good enough to come to us at the City Club, where, in our room, we could quietly and comfortably work. We encountered no serious difficulties, but had, indeed, a pleasant and satisfactory conference.

Mr. Barrett informed us that he represents Mr. Hearst in this matter, and that the proposed legislation is part of a general plan to have State Narcotic Laws, in all of our 48 states, in harmony with the National, or so-called Harrison, Narcotic Law—just as State Prohibition Laws were enacted widely to support the Volstead Act. Mr. Hearst, it appears, is engaged in a *world-wide crusade* to suppress the abuse or misuse of narcotics.

It was not possible to study thoroughly the entire Bill at one morning session, but during that short time we did find and discuss 3 items of vital import; which, if enacted into law, would affect physicians as follows: (1) An additional registration and license to administer and prescribe narcotics—the fee for which would probably be $1 per annum. (2) A physician convicted of violation of the law might be deprived of his *license to practice medicine*—not merely his license to prescribe certain drugs. (3) Physician is forbidden to prescribe, under any circumstances, more than—in the use of morphia, for example—½ gr. within 48 hours.

Mr. Barrett agreed with us in all 3 of the abovementioned objections, and expressed a personal willingness to make such alterations as might be required to make the Bill satisfactory to this body, but neither of us was authorized to proceed beyond that point. It was understood at the conclusion of that conference that we would report to Dr. Schlichter and that Mr. Barrett would also confer with Dr. Schlichter as to what further steps should be taken. Later, we invited Mr. Barrett to come here today to present his case or answer questions, etc., if this Committee so desired; and, we are informed that he will be here.

There are several committees to be called on today for reports, if their respective tasks have been sufficiently developed.

(1) Expert Testimony—Dr. Londrigan, Chairman.

(2) Osteopathy—if there be any new developments since last meeting—Dr. Sommer, Chairman.

(3) Newcomb Bills—Dr. Newcomb or Dr. Mahaffey.

(4) Veterans' Legislation—Dr. McBride, Chairman.

(5) Costs of Medical Care—Dr. Sherman, Chairman.

Incidentally, we wish to report that the next Tristate Conference is scheduled for February 18, in New York, and the program covers the following subjects:

(1) An Analysis of the Final Report of the Commission on Medical Education—the so-called Lowell Commission—presented by Dr. Rappleye, the Director of that study.

(2) Digest of the Final Report of the Committee on the Costs of Medical Care, by Dr. Van Etten.

(3) Description of the Endicott-Johnson Clinic, by Dr. Howard W. Davis.

Pending legislation at Trenton. Up to the present moment, few medical Bills have been introduced.

S. 125 bears upon the appropriation of funds to the Boards of Licensure and will be explained here today by Dr. McGuire along with his presentation of further information concerning the Princeton Commission's recommendations.

A. 110 is a new Bill, authorizing the Commissioner of Labor to issue registration certificates to Barbers. We have not yet secured a copy of that Bill and cannot report upon its contents.

S. 46 is a proposed amendment to the Workmen's Compensation Law which states that "proof of the industrial origin of a hernia may be by preponderance of evidence", and not, as at present, require *conclusive proof.*

We have in hand a communication from Dr. Ireland, regarding the School Physician's Program, which will be presented under the head of New Business.

The Journal. We have held, until the last, mention of the Journal. The Editor wishes, many times each year, that he could know how members feel about items published in the Journal, and he will never have, for illustration purposes, a better example than is afforded in the January Journal.

Confronted by what seemed to him *an emergency,* he cut loose from precedent and established form, set aside for future use much routine material already in type, *converted an emergency into an opportunity,* and delivered into the hands of our members a Journal of 122 pages, 84 of which were devoted to presentation of the available important facts concerning state medicine as it might affect them. It was, truly, an "herculean task"—and he can confess today that had he realized fully, in advance, just how gigantic that task would become, it probably would not have been undertaken.

Naturally, we have looked about to see how the situation was met in other states. Some State and some County Societies have supplied copies of "Medical Care for the American People" to the members of their special committees appointed to study the "Report", but, in so far as we have learned, in no other state have all Medical Society members been given copies of the Report, or anything else comparable to the amount and character

of information that the January Journal placed in the hands of our members.

We know that the January Journal is being read and studied, and we believe that it will have an increasing value during the next year or so, but only a few members have taken the trouble to express their opinions of it, and strange as it may appear, we have received many more responses from outside the state and requests for copies of the Journal have far exceeded the number available. The first request came from a physician in a mid-western city and was accompanied by a check for $3.60 for 12 copies, which he desired to distribute among friends. Following that, came a check for a year's subscription to the Journal. Other requests for and offers to purchase the January Journal have mounted to a total of *approximately 250 copies.* On the other side of the picture, we have a report that at one County Society meeting the Editor was severely criticized for not having lined-up with the A. M. A. Journal in an endorsement of the Minority Report; a criticism which the Editor does not, however, take to heart seriously, in view of his previous editorial statement concerning policy.

Henry O. Reik, M.D.,
Secretary, Welfare Committee

Dr. Lippincott: Mr. Chairman, I want to express my appreciation of the work of the Editor, as shown in the January Journal, and to say that I think he has presented to our members—all of the members of our State Society—the most complete, and the best prepared, document on the "Reports of the National Committee on the Costs of Medical Care" that I have seen, and has presented that matter in such form that the members of this Society have in their possession all information upon this question that could possibly be desired as a basis upon which to construct their individual opinions in preparation for voting upon the subject, when the time for doing so shall arrive. I move. therefore, that his report be accepted and approved, and that we give him a special vote of thanks for what he accomplished and gave to us through the January Journal.

The motion was seconded by several members, and unanimously adopted.

Chairman: Are there any matters in the Secretary's report to be acted upon?

Secretary: We have a telegram from Dr. Londrigan stating that the Medical Expert Testimony Bill has been prepared in association with a Committee from the State Bar Association, of which Committee Judge Porter is Chairman, and the Bill will be introduced during the coming week as from the Bar Association.

Chairman: If there is no objection, Dr. Londrigan's report will be accepted. Will Dr. Sherman report for his Committee?

Dr. Sherman: Our Committee has given consideration to this task but, as it will require considerable time to develop the work, we can at present only report progress.

Dr. Morrison: May I refer to Dr. Londrigan's report, and offer a suggestion that, inasmuch as there are many physicians practicing in this state but not members of our Society, careful consideration should be given to the wording of the law with reference to the Court's power to select "experts" for testimony in pending cases. If it can possibly be included in such law, I would suggest that provision be made—requiring the Courts to call upon the State Medical Society, or the County Medical Societies, *to submit lists of experts,* in the different medical specialties, from which lists the Courts should make selection.

Dr. Quigley: I will be very glad to take that up immediately with Dr. Londrigan and suggest the careful wording of that section of the proposed law.

Chairman: Is Dr. McBride prepared to report for his Committee on Veterans' legislation?

Dr. McBride: We can only report progress and explain that the Executive Secretary is in touch with conditions in Washington and has been advised by Dr. Woodward that there is nothing for us to do at present. We expect him to call upon us when needed.

Chairman: Has Dr. Sommer anything further to report for his Committee on Conference with the Osteopaths?

Dr. Sommer: Nothing further, Mr. Chairman. Dr. North presented our report at the last meeting, it was acted upon, and the proposition it contained was rejected. I suppose the Osteopaths will now introduce their own Bill without further consultation with us.

Dr. Tracy: I move that the report be accepted and the Committee discharged—with thanks.

Chairman: Will Dr. Mahaffey report for the Committee appointed to confer with Dr. Newcomb concerning the 3 Bills presented at the last meeting of this Committee?

Dr. Mahaffey: Those Bills have been revised in accordance with the discussion that took place here at the January meeting, and now read as follows: (Dr. Mahaffey read the 3 Bills seriatim, and each was approved by unanimous vote.)

Dr. Quigley inquired how many County Societies had taken action on the Report of the Committee on Medical Costs.

Several members reported for their own counties that special committees had been appointed to study that Report and to present their conclusions later.

Executive Secretary stated that, in so far as he had observed in the County Society Reports for publication in the Journal, the method of appointing special committees for study of the Report seemed to have been pretty general and that in some instances arrangements were being made for special meetings to be devoted solely to a consideration of the Report.

Dr. Sherman requested the Executive Secretary to ask for reports on this matter and to supply him with such information as might be in that manner received; which request the Secretary accepted and agreed to put into effect.

At this point, Mr. Barrett arrived, accompanied by Mr. Samuelson, and was introduced to the group by the Executive Secretary.

Chairman stated that he had arranged with Mr. Barrett to attend this meeting at 3 o'clock, to conserve his time, and would now ask Mr. Barrett to

explain to the Committee the Bill proposed as an amendment to the Narcotic Law.

Mr. Barrett proceeded to explain the reasons for offering the amendments, practically as stated in the Executive Secretary's report, and expressed the hope that the Welfare Committee, representing the State Medical Society, would approve these amendments; he having agreed to the changes suggested by Dr. Cosgrove and the Executive Secretary.

Mr. Barrett, having included in his discussion a recently revised copy of the Uniform Narcotic Law being urged for adoption by the States, promised to send 100 copies for distribution by the Executive Secretary.

Many questions were asked regarding various features of the Harrison Narcotic Act and the State Narcotic Laws intended to support the National Act, and at the conclusion of this discussion, in which Drs. Morrison, Quigley, Hagerty, Green, Fischelis, McGuire, Ulmer, McBride, and Steigerwald participated, the motion suggested by Dr. Quigley, but presented by Dr. Hagerty, and seconded by Dr. Coleman—to appoint a committee to confer with Mr. Barrett about the wording of the proposed Bill—was unanimously adopted.

Committee to Confer with Mr. Barrett: Drs. Schlichter, Green, Morrison, Sommer and Ulmer.

Executive Secretary presented a letter from Dr. Ireland, of the State Board of Education, as follows:

"February 4, 1933

To the Welfare Committee of the
Medical Society of New Jersey.

Gentlemen:

In behalf of the schools and the State Department of Public Instruction, I invite the Welfare Committee as a whole and its members individually to submit suggestions to me relative to the following:

(1) In face of the demand and the necessity for economy in school administration, how may local Boards of Education economize on the physician's program without obscuring the objectives?

(2) How shall we proceed to save the physician's part in the total school health program?

Underlying the demands for economy, which go so far as to advocate abolition of the physician and his work in the schools, are these problems of which we were always aware, but which the radical economist now magnifies, wholly to the exclusion of all facts in the situation:

(1) The indifference of some school physicians toward their work.

(2) The indifference of some school administrators toward the school physician and his work.

(3) The evident lack of understanding of the school health program on the part of general practitioner who does not and never has engaged in school work.

It is the purpose of the State Department:

(1) To encourage all local Boards of Education and all school physicians to conduct the medical aspects of the school health program in accordance with general policies laid down by the Medical Society of New Jersey for this department.

(2) To foster a spirit of coöperation between the school physician and the family physician, and, if possible, to recommend a program that will obviate any misunderstanding and lack of coöperation.

(3) To utilize the talent of the school physician toward the end that children shall become better pupils, hence effecting economy in school operation, but without usurping the prerogatives of parents or the obligation of parents to provide corrective measures.

(4) To defend the legal employment of school physicians in this time of evident danger to child health.

Respectfully yours,

(Signed) Allen G. Ireland, M.D.,
Director of Physical and Health Education."

Dr. Haggerty moved that this letter be incorporated in the Executive Secretary's minutes for distribution to all members of the Committee, so that all might be informed of the several points considered.

Dr. Morrison moved, as an amendment, that, in addition, a sub-committee of 5 members be appointed to consider Dr. Ireland's letter and to take such action as might seem desirable.

Dr. Haggerty accepted the amendment, and the motion, as amended, was seconded and adopted.

Dr. McGuire presented a copy of S. 126, introduced by Senator Reeves, regarding the moneys handled by the various State Licensing Boards, and explained how this would interfere with the work of these Boards. He stated also that it is rumored Senator Leap intends to introduce a Bill which would provide a separate Board of Examiners for the various groups of *drugless healers*.

Dr. Fischelis suggested that an effort be made, in relation to S. 126, to have the funds of these Boards exempted from the funds which would be required to pass through the Treasury.

Dr. Morrison moved the adoption of that suggestion, which was seconded and adopted.

Dr. McGuire asked Assemblyman Newcomb whether there had been as yet a party caucus on the Reeves' Bill, and if he thought it was to be made a part of the dominant party program?

Dr. Newcomb replied that there had not as yet been a caucus, in so far as he knew, but he thought there would be, and that this Bill might be included in legislation to be jammed through rapidly. He referred to Essex County as "the State of Essex", and suggested that further information might be obtained from politicians in that "State".

Dr. McGuire discussed the general problem these Boards would have to deal with in the event that S. 126 became a law, and reminded the Welfare Committee that it had at a recent meeting voted to take the same stand in regard to this proposition as it did 2 years ago when the Abell Commission Bills were being considered.

Upon motion of Dr. Mulford, the Committee again voted opposition to this matter as represented in S. 126, and his motion was adopted.

Dr. Quigley presented, and had the Executive Secretary read, a letter concerning the sale of barbital, and then suggested that a special sub-committee be appointed to consider this and kindred drugs and be given power to take such action as seemed proper; which suggestion was adopted.

Committee to consider legislation regarding barbital and similar drugs: Drs. Quigley, Chairman; Quinn, and Haussling.

The meeting then adjourned.

Henry O. Reik, M.D.,
Secretary, Welfare Committee

TWENTY-THIRD ANNUAL CONFERENCE STATE AND LOCAL HEALTH OFFICIALS

Report prepared in the State Health Department under the direction of

J. Lynn Mahaffey, M.D.,
Trenton, N. J.

Attended by 200 public health workers from nearly all sections of the state, the 23rd Annual Conference of State and Local Health Officials meeting in the Assembly Chamber at Trenton, on February 10, 1933, focussed attention on important health problems and ways of attacking them. The attendance was somewhat less that the record conferences of the 2 previous years, but the use of amplifiers, for the first time, brought the remarks of speakers clearly to each delegate.

Harry P. Croft, C. E., Chief, Bureau of Engineering of the State Department of Health, read a paper entitled "Sanitation of Swimming Pools". He reviewed the provisions of a Bill, A-167, which would give the Department control of swimming pools and baths by means of a license system. A license would be contingent on approval, by the Department of plans and specifications for the construction and alteration of a pool or bath, and the observance of rules for operating such a public institution. The license fee would be $10, but payment of such fee would not be required of state, county, municipal, charitable or religious organizations operating pools. The right of local boards of health to make rules and regulations not in conflict with the law and state-wide requirements, is preserved in the Bill.

Chester G. Wigley, C. E., consulting engineer from Atlantic City, presented evidence, gathered in the Raritan River Survey, showing possible dangers to health, from bathing in polluted waters.

Discussion of the Bill dealt chiefly with the need and value of preserving local control over the operation of swimming pools, and resulted in the appointment of a committee of local health officers to assist in changing the proposed law to meet this need.

William H. MacDonald, Acting Chief Bureau of Local Health Administration, of the State Department of Health, pointed out, at the afternoon session that diphtheria still challenges the medical profession and public health workers in this state. In spite of the striking morbidity reduction of 50% in 1931, and 25% in 1932, still there occurred 1400 cases and nearly 100 deaths from this disease last year (1932). Of the many factors which contributed to this reduction, programs of active immunization with toxin-antitoxin and toxoid were regarded by Mr. MacDonald as the most potent.

Diphtheria Still a Menace

William H. MacDonald

Acting Chief, Bureau of Local Health Administration, State Dept. of Health, Trenton, N. J.

Reduced case and death rates from diphtheria in New Jersey, in 1932, show the efficacy of immunizations, yet challenge our united efforts both to hold the advantage gained and to reduce further the prevalence of this disease.

The number of reported cases of diphtheria in 1932 was approximately 1400, and the number of deaths from this cause was approximately 100. Both the case rate, 33.12 per 100,000, and the death rate, 2.28 per 100,000, were the lowest annual rates from this disease recorded in New Jersey. About 10 years ago, in 1922, the recorded cases and deaths from diphtheria were more than 5 times the number reported last year. This is indeed a creditable showing and is a striking example of results which actually have been accomplished by concerted efforts to apply preventive principles and measures, having a real value, in controlling a specific disease.

Many factors have played some part in bringing about this reduction. We must agree, however, that programs resulting in the use of toxin-antitoxin and toxoid as immunizing agents have been the great factor in reducing diphtheria to its present level.

About 18 years ago toxin-antitoxin, as a diphtheria preventive, was introduced in New Jersey as a public project. For the first few years it was used very little outside a few institutions controlled directly by the state. During the winter of 1920-21 it was offered, as a public project, in a few public schools. From that time, the use of toxin-antitoxin gradually spread. The term *gradually* is used advisedly; although parents, as well as public officials, were anxious to curb diphtheria, toxin-antitoxin, as a means of doing this, had to be sold to them. Many were skeptical, some were opposed, although a great majority were entirely open-minded, and to gain their interest they needed only to have the possibilities explained and demonstrated. To do this, however, involved an educational program through talks, pamphlets, conferences and, perhaps most important, by practical demonstration. In order to give practical demonstration, and at the same time to immunize some children, Schick tests and toxin-antitoxin were offered publicly to children in groups such as in school. Such offers in a community, by the local Board of Health or Board of Education or both, created confidence in this means of immunization against diphtheria and started many parents taking their children to family physicians to receive the injections. Public offers of this type continued and increased until, by the middle of 1928, such offers had been made in 185 municipalities.

At about this time, a special State-Wide Committee for the Prevention of Diphtheria began to function. Through the added impetus derived from this Committee, diphtheria immunization gained momentum. In Annual Health Reports for 1930, it was stated that some public offer of diphtheria immunization had been made during that year in 330 municipalities. It was during the period the State Committee was operating that greater emphasis was placed upon having children below school age immunized, and parents were being urged to secure such immunization, particularly for young children, from family physicians. The need for reaching this group of very young children was shown in the relatively high death rate from diphtheria in this group. It had also been established that the

percentage of children susceptible to diphtheria, as shown by the Schick test, was greater in this group. Since the State Committee disbanded, there has been less organized work on a wide scale to secure immunization, and it is well now to check up on current conditions.

It must be kept in mind that even if, as a result of special efforts, a large proportion of children in a community are immunized in a single year, the next year sees the arrival of new children. Therefore, in order to keep the percentage of immunes in any group of children up to a standard, it is necessary that new members of the group be immunized; and, some project to accomplish this must be applied.

It has been suggested the time may come when diphtheria is so reduced in prevalence that there will be little need for stressing immunizations. Up to the present, however, we cannot take such a comfortable attitude, knowing that there occurred last year 1400 cases and about 100 deaths from this disease for which we have a definite and effective preventive. While this number of cases and deaths is less than the recorded numbers in 1931, the reduction between 1931-32 was not nearly so marked as between the years 1930-31. Evidently throughout the state as a whole, immunizations must proceed.

In the absence of an intensive campaign on a large scale, has there been a dropping off in diphtheria immunizations within the last 1 or 2 years? All we can say is that indications are that this is true. In 1931, the number of local boards of health reporting some public offer of diphtheria immunization in their community was 52 less than in 1930. The number of persons reported as receiving diphtheria protective injections at such public clinics in 1931 was 1/3 less than the number reported as being so treated during the previous year. It is certain, within the last 2 years there has been an increase in the number of parents who are not financially able to pay for toxin-antitoxin treatments by family physicians, and, also, there has been an increase in the number of parents who feel they cannot afford to pay the cost of any injections which may be postponed. It seems very likely, that relatively fewer children are now receiving anti-diphtheria injections by family physicians.

While it is freely admitted that diphtheria occurs in communities of all types and sizes, do case reports show a preponderance of cases per unit of population in any selected group of municipalities? Case reports for 1932 indicate an affirmative answer to this question. During that year, by far the higher proportionate number of reported cases of diphtheria were municipalities above 25,000 population, the highest proportionate number being reported from the cities of over 100,000 population. In townships, the highest proportionate number of reported cases occurred in the townships above 10,000 population, as compared with townships of lower population groups. This indicates there should be a continued and increased activity to secure diphtheria immunizations in larger communities.

Programs of diphtheria immunization are considered generally from 2 angles: The child of preschool age, and the school age group. Theoretically, if a very large proportion of pre-school age children are immunized, within a few years there need be given less attention to the school age group. Such a point evidently has not yet been reached in New Jersey as a whole, inasmuch as in 1931 more of the reported cases of diphtheria occurred in children from 5-9 years of age than in the group of under 5 years. A considerable number of cases also occurred in the group, 10-14 years old. The distribution holds true generally for communities of all sizes. Of the total reported cases in 1932, 48% occurred in children ranging from 5-14 years of age.

It is granted that nearly all children between these ages attend school; therefore, if the diphtheria battle is to be won, we cannot *yet* neglect urging immunizations among school children. Methods found practical in organizing and carrying out Diphtheria Prevention Clinics for school age groups are so generally known that there seems to be no need to dwell upon means to set up such programs.

In the pre-school age group, that is, among children less than 5 years old, nearly 31% of the diphtheria cases reported in 1932 occurred. If there is greater need to show the desirability of diphtheria prevention work in this group, it may be found in the fact that 52% of deaths from diphtheria in 1932 were among these young children.

While there is no health official who would not rejoice to have all children of all age groups given toxin-antitoxin or toxoid by the family physician, as part of his private work for the family, the accomplishment of such a plan seems even less likely under present economic conditions than it was some years ago. Health officials, however, still are urging, and will continue to urge, that young children, in particular, be taken to family physicians for diphtheria immunization. How many of the young children throughout the state are receiving immunizations by private physicians is unknown.

No doubt the proportion varies in different communities depending somewhat upon the policy and activity of the local health department, the character of the population and the interest local physicians take in the matter. A survey recently conducted through the Bureau of Child Hygiene of the State Department of Health, indicates that of a selected group of 11,000 children between 1 and 2 years old, 28% had received diphtheria immunizing injections from some source. There was great variation in the percentage reported immunized in different counties. How this pre-school age group can best be reached in order that a higher percentage be protected against diphtheria early is a very practical question which doubtless will be discussed by the others at this Conference.

I wish, and have attempted, merely to point out: first, that there has been a marked reduction in diphtheria in New Jersey; and second, that in spite of this reduction, work to secure immunization must be stimulated and continued. I also wish to point out that large communities even yet appear to have a relatively greater problem with diphtheria than smaller communities; that judging from case reports, in New Jersey immunization of children of school age should not yet be neglected as a means of reducing the prevalence of diphtheria, and that there is need for still greater emphasis upon protecting the young pre-school age children by means of diphtheria preventive injections.

A City Protects Its Young Children

Frank J. Osborne, Health Officer of East Orange and former Chairman of the New Jersey Committee for the Prevention of Diphtheria, described how one city health department has sought to attain more general immunization of young children. The plan includes sending a return-postcard to a doctor reporting a birth, asking if he will endeavor to have the baby immunized when 6 months old, or if he desires the health department to assume this responsibility. About 1/3 of the 240 physicians who returned such cards in 1932 asked the Health Department to attend to this matter.

Reminders that babies should be protected against diphtheria and smallpox are sent to parents with the birth certificate; again when the children are

6 months old; and when a year old; and a final check-up is made when school age arrives. These reminders are now delivered by the local department's nurses, who add a personal word to the plea carried by the printed communication. Parents are urged to go to their family physicians for immunizing services, but clinics are maintained for those who may desire to patronize them. Last year, 2353 children were given protective treatments at such clinics, and 910 received protection from physicians privately. All this was in addition to similar work in the schools.

The Physician's Responsibility

Dr. Samuel Haven, of Morristown, set forth in a convincing manner, how a practicing physician can secure protection of children under his care, not only against diphtheria but against smallpox and, in some cases, against typhoid fever. Dr. Haven maintains systematic records by which parents are told when their children should receive the various protective treatments. He also gives them to understand that his advice is to be followed in these matters as in others if they expect to retain him as their physician. The need of active immunization and its value is explained carefully and the decision put squarely up to the parents at the proper time. Dr. Haven finds that his method gets results and is a valuable service which parents in general welcome and use. In Dr. Haven's opinion, responsibility for securing the use of approved forms of health protection might be divided about as follows: family physician, 60%; health departments, 30%; individual 10%.

Discussion

Discussion of these 3 papers on diphtheria prevention was conducted by Dr. Henry O. Reik, Executive Secretary of the Medical Society of New Jersey; Dr. C. V. Craster, Health Officer of Newark; R. C. Errickson, Health Officer of Long Branch; and Fred M. Williams, Health Officer of Rahway.

Dr. Reik described the situation developing since the State Committee had finished its work and withdrawn, which he called to the attention of medical men in an editorial appearing in the February issue of the State Journal (see page 155). His plea was for re-activating the County Diphtheria Committees and renewing personal interest in diphtheria prevention on the part of practicing physicians.

Dr. Craster said that immunization of 50% of Newark children below school age had come through the activities of the City Health Department. About 70% of young children in Newark are under the observation of Public Health Nurses, and approximately 70% of these children have been give T. A. or toxoid.

Mr. Errickson said the Public Health Nursing Association of Long Branch coöperates with the Health Department in maintaining a pre-school clinic for diphtheria immunization. During the past 6 years, an average of 100 young children a year have been treated at this clinic. In the same period, 195 young children were given toxin-antitoxin or toxoid by physicians, privately. About half the pre-school children in this city are known to have received preventive treatments. Education by the nurses is thought to have influenced many parents in this matter.

In Rahway, a somewhat unusual plan was inaugurated in 1929, whereby each physician in the city agreed to administer free, to any child brought to his office during regular hours on certain days, 3 doses of toxin-antitoxin. The material was supplied by the local health department. This plan secured the treatment of 700 children, in 1929 and 1930, many of whom were below school age.

Playlet Teaches Lesson

The Annual Demonstration-Playlet dealt with the work of District Health Officers and employed 2 scenes. The first, in the District Office, developed situations relating to scarlet fever on a dairy farm, Schick testing in a public school, taking diphtheria cultures, rabies control, preparation and advertising of local health ordinances, nuisances other than public health nuisances, reporting and investigation of cases of communicable disease and the testing of water.

The second scene featured the inspection of a roadside stand, which had been set up at the front of the room and was unveiled at the proper time.

Public Health Activities Illustrated

Motion pictures taken by 2 East Orange physicians and depicting the activities of the health department of that city, opened the evening session. The audience was shown through the splendidly arranged building which houses the department and then accompanied clerks, nurses, inspectors, the bacteriologist, medical examiner and the health officer on their various undertakings of the day. Suitable captions served to relate these activities to one another so that one received the impression of actually viewing many sides of a single program. The culminating statement that all these services were being furnished from only 1 cent of the taxpayers' dollar brought forth that friendly feeling of approval which is an important objective of publicity.

Health Publicity and the Press

Frederick L. Ferris, editorial writer for the Trenton Times, following this example of pictorial publicity, described in lively fashion "Health Publicity and the Press". Mr. Ferris characterized publicity as a combination of news, psychology, English and salesmanship. Without news value, publicity items submitted to a paper are merely bids to secure free advertising, he said, and are promptly discarded by the Editor. The construction of a news story, with the substance of the story contained in the opening paragraph and details following in decreasing order of interest, was explained. Mr. Ferris praised Public Health News, the monthly bulletin of the State Department of Health, which had to be discontinued last July because of lack of funds. He felt that the returns from such a publicity and educational organ far exceeded its costs.

Costs of Medical Care Discussed by a Committee Member

Dr. Haven Emerson, Professor of Public Health Practice and Executive Officer of the Delamar Institute of Public Health, Columbia University, was the principal speaker at the evening session. Dr. Emerson's subject was "The Report of the Committee on the Costs of Medical Care, and Its Bearing on the Organization of Public Health Work". He reminded the gathering that the duties of health officers bring to their attention many of the matters with which the Committee, of which he was a member, had to deal. Such matters as: the effect of disease on the population as a whole; trends in communicable diseases; social application of preventive measures; value of mass-production methods in securing health protection; and the effects of health education; become part of the working

knowledge of experienced health officials. He pointed out that their point of view was different from that of the practicing physician who dealt with individuals and saw more clearly the particular problem as manifested in each person.

Dr. Emerson called attention to the remarkable fact that the 48 members of the Committee, after 5 years' study, should come to conclusions so nearly in perfect agreement. He described briefly the various studies which the Committee had made and some of its findings.

He said that even those who can afford the best medical care are not receiving the *optimum* of service per year, and persons of small means can secure far less service than they require. The study had shown that where medical services are organized on an efficient basis, the best medical care is being secured at about the same *per capita* cost ($30 per year) which is now being paid generally throughout the country for inadequate care.

The fact that the cost of sickness is unpredictable and cannot be budgeted in the ordinary way, was an important reason for the Committee's feeling that *group payment* of sickness costs would be the logical remedy for the present excessive cost to some and the unequal distribution of needed services to all.

Dr. Emerson's interpretation of the conclusion of the Majority Report was that groups of individuals should arrange with medical groups for needed medical services and that the next move is up to the public.

Note: Dr. Emerson's paper is not given the space it deserves in this review because the Report was covered so fully in the January issue of the Journal of the Medical Society of New Jersey.

AMERICAN COLLEGE OF PHYSICIANS

Reported by Dr. W. Blair Stewart,
Atlantic City, N. J.

(This is a copy of the report submitted by the Committee on Public Relations of the American College of Physicians, of which committee Dr. Stewart was, at the time, Acting-Chairman. It was approved by the Board of Regents at the meeting of the College, in Montreal, and, later, Dr. Stewart was reëlected Chairman of the Board of Governors of the College for a new terms of 3 years; which makes him, automatically, a member of the Board of Regents for the same period.—Ed.)

The final report of the Committee on the Costs of Medical Care, as published in book form, is entitled: "Medical Care for the American People." It is the twenty-eighth publication of a series representing an extensive and intensive effort to collect factual data concerning the numerous problems involved. These studies were made over a period of 5 years, and after the expenditure of an extraordinary amount of thought, effort and money. The facts presented are of immense importance to the country as a whole and the medical profession in particular. They deserve the most careful study and consideration.

The detailed information is contained in the 27 interim reports previously published, and only a brief summary is included in the "final report", the main emphasis of which is placed upon certain definite *recommendations* proposed by the Committee as a basis for a plan of re-organization of medical practice, so as to meet the social and economic defects of the existing system brought out by the factual data. These *recommendations* are in the form of separate *majority* and *minority reports*, with a few members of the Committee declining to assent to either.

The wide-spread discussion which has followed publication of the final report is centered upon the *recommendations*. This is most unfortunate because it has over-shadowed the great value and significance of the *studies* upon which these recommendations are, presumably, based.

It is the opinion of your Committee that the publication of definite recommendations was premature and unjustified by the facts presented. A careful analysis of the text of the reports shows that the recommendations are really only tentative suggestions for future consideration and careful experimentation, and in our opinion should have been offered as such.

It is also our belief that the actual factual data contained in the various reports are of such value that they deserve careful study by all members of the medical profession. These facts reveal a situation which calls for consideration followed by action leading to some modification of existing medical practice; and, in any such modification the medical profession should take a leading part.

It would be very unfortunate if prejudice, caused by differences of opinion concerning the recommendations, should belittle the value of the facts themselves. It would be still more unfortunate if either prejudice or inaction should deprive the medical profession of its rightful position of leadership in any program for remedying existing inequalities or injustices in the practice of preventive and curative medicine.

Our Committee recommends, therefore, that the Fellows of the American College of Physicians be urged to study, individually, the facts presented in the Report of the Committee on the Costs of Medical Care, uninfluenced by such acrimonious discussion as has been raised by publication of the various recommendations; and, we also recommend that the representatives of the organized medical profession in each community be urged to consider these problems carefully, in the light of their varying local needs and conditions, for it is our belief that by this method the enlightened leadership of the medical profession can point the way to improvements of great value, both to the public and to the medical profession itself.

School Health Department

SOME NEW ITEMS IN SCHOOL HEALTH PROGRAM

Allen G. Ireland, M.D.,
Director of Physical and Health Education,
State Department of Education, Trenton

Are you familiar with the Bills dealing with school health problems now before the Legislature? They are deserving of your support. No doubt Dr. Marcus Newcomb can furnish you with any desired information, he being the Assemblyman from Burlington County. You may address him either at the State Capitol or his home in Brown's Mills.

We are pleased and encouraged by the complimentary letters being received from all over the country concerning our publication entitled—"A School Health Program for the Physician".

For the rental of an audiometer and the services of a nurse-operator, address the Supervisor of Child Hygiene Nurses in your territory or communicate direct with the Child Hygiene Bureau of the State Department of Health, at Trenton.

In my child health work with the New Jersey Congress of Parents and Teachers, there are 3 things I am attacking in which physicians can be of great help by giving me local support. They are:

(1) The sale of candy at school.

(2) Attendance of young children at evening meetings.

(3) The over-emphasis given to devices designed to improve school attendance at the risk of child health.

Michigan is having a severe epidemic of lethargic encephalitis following upon the unusual incidence of influenza. Several New Jersey physicians have warned me that we should be expecting a similar occurrence here, and I am passing the statement on for your information.

Strange as it may seem, we are constantly hearing of gonorrhea among elementary school pupils. The tragedy of it is the obscurity of these cases. School physicians are almost helpless until the definite facts in a given case are revealed to them. In this serious situation, the Bureau of Venereal Disease Control, in the State Department of Health, has been most coöperative and helpful. We suggest that you call upon the Bureau for assistance, not only after a case has been discovered, but to present the facts of social hygiene to principals and teachers. We have from leading school administrators endorsements of the good work the Bureau is doing.

The School Lunch

The following remarks are from a pamphlet prepared by the writer for early publication: "No growing child will thrive properly on 2 meals and a 'paper bag' luncheon daily. And it is stretching a point to concede that children are receiving that much, for it is well known that many, indeed, armies of children, do not have adequate breakfasts. Many are compelled to go without either breakfast or luncheon. And, not infrequently, the evening meal is not what it should be.

The child's real allotment, his need, if you would have him develop normally in mind and body, is 3 full meals, and in many instances an additional luncheon is needed. Lunches of cold, sodden food, hastily and poorly prepared, packed unattractively, become palatable and more appetizing when taken with a bowl of hot soup or cocoa. More of the lunch is eaten than before; also, it is eaten more slowly, and the digestive processes are most thoroughly stimulated by the warm food.

The school lunch is more than worth its cost if it does nothing more than abolish the street peddler and the store lunch. Here the usual fare is soda and pastry, served poorly and hastily, and with little regard for etiquette. Such conditions are ruinous to health and may be equally harmful from a social viewpoint. Bad habits are formed, both with regard to the selection of food and the spending of money. Furthermore, there is always exposure to traffic dangers when pupils are permitted to leave the school grounds to visit neighborhood stores and lunchrooms. Because of the haste and element of play that are bound to enter, the danger is particularly acute.

The school lunch should not be regarded as a sufficient means for the correction of malnutrition, as malnourished children usually need careful medical attention and seldom improve without it."

State Health Department

AN ADDRESS DELIVERED TO THE WOMAN'S AUXILIARY

J. Lynn Mahaffey, M.D.,

Director of Public Health, Trenton

Helpful attitude of the State Department of Health toward the medical profession, not only in normal times but during the current economic situation, was explained to the Woman's Auxiliary to the State Medical Society recently at the Contemporary Club in Trenton.

The services of the many clinics conducted by the Bureau of Child Hygiene, a sub-division of the State Department of Health, were thoroughly explained, with emphasis upon the fact that the Child Hygiene nurses, approximately 150 in number, have specific instructions to advise those with whom they come in contact always to call a physician for purely medical services and advice.

The attitude of the Department, as formally explained to the auxiliary, is as follows: There is a feeling among us that some physicians in the state believe that our Department is encroaching on their practice. In answer to that, I desire to say that the State Department of Health is fully cognizant of the effects of the depression on the income of the physicians, and we are doing everything possible to direct patients to consult their family physician. The line between proper and improper duties in the work of the 150 nurses in our Child Hygiene Bureau is so finely drawn that it is almost impossible to keep within bounds. Our nurses *always advise* the people they are visiting to *consult a physician for medical services.*

It is a common occurrence nowadays to see Dispensary patients coming in automoblies for free treatment in the hospitals. Many such persons are working and receiving good salaries. The present generation seems to think physicians have no use for money, and almost every dispensary in the state is imposed upon.

Many of your husbands will today treat some of their former pay-patients in dispensaries, for which service they will receive no compensation, and ¾ of the hospitals in this state are operating under a terrific expense which will end in a large deficit, and an appeal to the public for financial aid.

No physician objects to aiding patients who are unable to pay; indeed, the physician has gone far beyond what could be reasonably expected of him, and there should be a closer check-up on those who are able to pay.

The greatest *welfare body* in the community is the State Department of Health. We approve your water supplies and check up on the purity of your foods. We record your births, marriages and deaths, and by our contact with the 563 local boards of health in the state, which are under our supervision, do every possible thing to carry on good public health work.

At its January meeting the Health Department voted to sponsor 2 Bills before the 1933 Legislature. One provides for state regulation of swimming pools and public baths, indoor and outdoor, with a licensing fee of $10 annually. The Department was actuated by the fact that swimming pools and baths are the known public potentially important sources of dissemination of disease. The number of pools in New Jersey is rapidly increasing, many of them in small communities where they are not subjected to adequate local health

rules and inspections. The Bill would authorize the department to prepare rules and regulations for enforcement by the State Department of Health and that includes regulation of modern sanitary facilities in such establishments.

The other Bill provides for safeguards against child marriages in New Jersey and revision of the marriage license law to bring it up to date. One change proposes that children under 16 years of age applying for marriage license shall have not only the consent of the parents, but also the written consent of the Judge of the Court of Common Pleas in the County where the contracting parties reside.

Communications

SECOND INTERNATIONAL GOITER CONFERENCE

(Dr. Martin B. Tinker, 404 Savings Bank Building, Ithaca, N. Y., requested presentation of this announcement to our members, and further information can be secured from him.)

The American Association for the Study of Goiter has arranged for a large representative American Delegation to go to the International Goiter Conference at Berne, Switzerland, August 10, 11, and 12, 1933.

The Delegation will be made up of the Officers and Members of the Executive Council, Members of the Invitation Committee, the Geographic and Delegates-at-large of the A. A. S. G., representatives of the leading Goiter Clinics, the National Medical and Surgical bodies of Canada and the United States, and those from the United States Army, Navy, and Bureau of Public Health.

The Committee in charge of mobilizing the Delegation has secured an exceptionally low rate for the voyage on the S. S. Pres. Roosevelt of $215.55 from New York to Havre and return. The sailing date is July 26, and the ship should reach the French port August 3. This will allow sufficient time for a leisurely trip to Berne, with 2 or 3 days for Paris. The return voyage may be made on any cabin vessel of the Line by payment of the regular tariff on vessel selected, less approximately ½ the amount of reduction allowed on the round trip passage on boats of the Harding-Roosevelt class.

A special feature of the going voyage will be an attractive and educational round-table goiter discussion program. There will be daily sessions, each one of which will be conducted by some outstanding man.

Members of the medical profession interested in goiter, who are contemplating going to Europe in 1933, should not fail to take advantage of this exceptional opportunity.

FOURTH COUNCILOR DISTRICT MEETING

(A letter from Dr. James A. Fisher, Councilor, of the Fourth District.)

The Camden County Medical Society will be the host of the Fourth Councilor District Meeting, to be held April 4, 1933, at the Camden Club, 315 Cooper Street, Camden. Dinner at 6 p. m., prompt; price $1.50 per person; with the assurance of a nationally-known speaker. The local County Society is also arranging an interesting Clinical Program to follow the Dinner. Reserve that date on your calendar.

SPECIAL CANCER STUDY COURSE

(A letter from the Philadelphia County Medical Society extending to New Jersey physicians an invitation to enjoy some of the privileges prepared for its own members; and offering this gratis. We sincerely regret that we have not space for the detailed program, which is excellent in every particular.—Ed.)

Dear Dr. Reik: The Committee on Cancer Control of the Philadelphia County Medical Society is arranging a Cancer Study Course, in Philadelphia, on April 11, 12, 13 and 14, with *day sessions* in the hospitals, and *evening sessions* at the County Medical Building. We are inviting physicians who are interested, from neighboring states, as guests, and since *no fee is involved,* it occurred to us that it would be well, perhaps, to ask you to publish this program in your Journal, or make reference to it as you see fit. I would be very glad if you would send me a copy of the Journal, showing what reference you have made to it.

Yours very sincerely,

G. E. Pfahler, M.D., Chairman.

PASSAIC COUNTY MEDICAL SOCIETY FREE POST-GRADUATE LECTURES

During April and May our Society will give a series of free lectures, on Friday afternoons at 4.30, in Paterson and Passaic—the program for *April* follows—the *May* program *will be announced later.*

April 7. "Treatment of Diabetes", by Dr. Edwin T. Hauser, Associate Clinical Medicine, Cornell University Medical College, New York City.

April 14. "Diagnosis and Treatment of Certain Heart Disorders in Middle Life", by Dr. Lewis A. Connor, Professor of Medicine, Cornell University Medical College.

April 21. "Recent Advances in the Diagnosis and Treatment of the Anemias", by Dr. Ruben Ottenberg, Associate Attending Physician, Mt. Sinai Hospital, New York.

April 28. "Endocrinology", by Dr. A. S. Blumgarten, Attending Physician, Director Endocrin Clinic, Lenox Hill Hospital, New York City.

Those interested in attending these free Post-Graduate lectures will please communicate with the Secretary.

Wayne W. Hall, M.D., Secretary

Woman's Auxiliary

WHAT EVERY WOMAN SHOULD KNOW ABOUT CANCER FOR HER OWN PROTECTION AND THE PROTECTION OF HER FAMILY; AND HOW THE MOTHER OF THE FAMILY MAY BECOME THE HEALTH DEPARTMENT OF THE FAMILY

Joseph Colt Bloodgood, M.D.,

Associate Professor of Surgery, Johns Hopkins University Medical School, Baltimore, Md.

(An address prepared especially for the meeting of the Woman's Auxiliary to the Passaic County Medical Society, in Paterson, Oct. 13, 1932.)

It is remarkable how little one must know for protection against cancer, and how much protection that little knowledge will give. That small sum of knowledge, however, is essential; and, in

addition, that amount of knowledge is of no value without confidence in the medical profession.

Periodic examinations and preventive medicine are like a new religion, and the majority of people must be reached just as they have been reached in the past by new religions. This so-called personal liberty, and that all men and women are equal before the law, makes it exceedingly difficult to get people to accept the new scientific truth of preventive medicine and periodic examinations.

Cancer of the skin and of the mouth and of the cervix in mothers will be relegated to preventive diseases when the majority of the people accept voluntarily the rules of modern preventive medicine, which are: Select a physician and dentist while you are well. Go to that physician and dentist, while you are well, for a so-called physical examination and ask their advice as to future examinations, and report to your physician or dentist the moment there are any warnings which, everybody will know, were not observed the day before. It is just as easy, and much more valuable, to discuss with your dentist and physician certain rules of health which should be followed, and you should learn all you can about the possible signs and symptoms which would justify your seeking their advice at once.

The officers and enlisted men of the army and navy are compelled to submit to the protection of periodic examinations, but they cannot be compelled to report the moment they observe any unusual sign or symptom. So long as they are able to go on with their daily duties, there will be no examination. It would be possible, therefore, among those compelled to submit to annual physical examinations, to lose all the protection that confidence in the medical profession gives—if the individual does not return for examination the moment there is any sign or symptom of trouble. For this reason, people who have confidence in the medical profession and follow the physician's advice, will have better protection than those who are compelled to have the annual examinations only. This is a very important new point of view.

Experience teaches me that among the adult population who seek periodic examinations of their own free will, they are much more apt to report to their physician or dentist the moment they observe any warning signs or symptoms.

The majority of physicians and dentists do not urge their patients to return annually for physical examinations. The majority of obstetricians, in spite of their admission that it is the greatest protection against cancer of the cervix in mothers, do not give this information to their patients. It would appear that in this country less than 10% of mothers who have no symptoms have had a periodic examination since the birth of their youngest child. They seldom go for the examination unless there have been local symptoms suggesting the need for such an examination. The majority of mothers are today ignorant of the protective value of pelvic examinations at proper intervals after the birth of their last child.

The majority of dentists and physicians fear that suggesting periodic examinations, and many of the other rules of modern preventive medicine, will be misconstrued as an attempt to increase their practice, and that many of their colleagues will look upon this as a form of unjustifiable advertising.

It would appear that the best solution of the problem of periodic examinations is through the mother. More and more expectant mothers visit their family physician, or the private or public clinic, the moment the condition of motherhood is realized. From this moment to the birth of the child, the mother receives the full protection of certain examinations and certain definite treatments. After the birth of the child, the mother receives the protection of the modern science of obstetrics and gynecology. All the possible injuries of child-birth are repaired, but from this moment future protection varies. With the majority of physicians and clinics, public or private, protection by periodic examinations rarely goes beyond the year, and usually less than a few weeks.

There is no better time to instruct a mother about her own protection than when she has just become a mother. She can be taught, and she wants to learn, all there is to know about the protection of her child. The first few years of a child's life are filled with protective measures. After birth silver nitrate is dropped in the eyes—in some states this is the law. In France and a few other localities the infant is given a tuberculin vaccine which has been developed through researches in the Pasteur Institute in Paris. Within the next 6 months the child is vaccinated against smallpox. In spite of the fact that smallpox would arise again if vaccination were neglected, this vaccination is not universally compulsory. The mother is taught infant feeding. In regions where goiter is prevalent, the children get iodine during the school years. The tonsils and adenoid areas are looked after. The dentist examines the teeth. Ultimately, x-ray pictures will be made of the teeth at certain ages. Deformities of the teeth which are very unsightly can be prevented by these periodic x-ray studies and by the proper application of gold bands when the teeth are out of place. There is no good reason why any boy or girl should grow up with such deformities.

There seems to be no difficulty about getting the majority of mothers interested in the protection of their children and, as a rule, the family physician, whether also obstetrician or pediatrician, or all three, aids the mother and instructs the mother on the protection of her child's health. With few exceptions, the mother herself is neglected after the birth of the child. The most impressive protection which has been accomplished is—care of the nipples. My studies demonstrate that less than 1% of mothers who nurse their children suffer from abscess of the breast, whereas 30 years ago more than 30% of mothers who entered a surgical clinic with a benign or malignant tumor of the breast gave a history of an abscess during the period of nursing her child. This protection has been accomplished by teaching the mother how to keep the nipple clean and how to protect it the moment there is any irritation. But rarely today does the physician attending the mother before and after child-birth warn her that a neglected irritation of the nipple when she is not nursing her child, has almost the same relation to cancer of the nipple as a neglected irritation of the nipple during the nursing of the child has to an abscess of the breast. Paget, of London, a great surgeon and pathologist, more than 70 years ago described cancer originating in the nipple. He said then, that if these women had paid more attention to the irritation of the nipple in the beginning, they could have been cured by simpler means. Paget should have added that no woman ever had been cured after having delayed matters until the nipple had been completely destroyed by the disease. Paget's cancerous nipple is just as much a preventable disease as is abscess of the breast during the nursing of a child.

If the obstetrician is instructing the mother on care of the nipple, why should he not carry the instruction to the care of the breast? Every physi-

cian who makes a physical examination, either as an annual survey or because of symptoms, should make an inspection, transillumination, and palpation, of the breast. During this time, and during the care of the mother after the birth of her child, and on all occasions of any physical examination, the woman should be told that: when she experiences any sensation in one or both breasts; or feels any lump or hardness; or notices any irritation of or discharge from the nipple; or any pulling in or other change in the nipple; she should at once seek an examination. When women are examined immediately after discovery of the first sign or symptom in the breast, the chances of discovering a cancer are least, and the probability of curing the starting cancer, if discovered, are the best.

The correct message in regard to the breast has reached and been accepted by many more women, than has the message in regard to the uterine cervix in mothers. Today, women with *early cancer of the breast* are much more numerous than those with *early cancer of the cervix*. The protection of women against cancer of the breast and cervix rests on the same principles of periodic examinations and reporting for observation the moment there are warnings. Periodic examinations for the protection from cancer of the cervix in mothers is much more important than for the breast.

When the child is born, physician, nurse, and mother must look for skin defects, because if they are neglected those birth marks or moles or other nodules may grow and then, when treated or removed must leave an unsightly scar. Now is the time to tell the mother to look for skin defects in all members of the family, and to have those that should be treated or removed attended to *then and there*. Really, the birth of a child into the family can be employed as the best incentive toward the beginning of a life, for all the family, with better protection against disease. It is quite true that all women, whether beautiful or not, pay attention to any skin defect which is visible to others. This is why the evening dress and the bathing or athletic costumes which expose more of the body, serve as added protection against cancer of the skin.

The child's mouth, especially when the teeth begin to erupt, will become the subject of discussion and attention, and then is a good time for the family physician to tell the mother the essential features for protection of all the family from cancer of the mouth. In recent years, beautiful women have taught men how to smoke, even to excess, without increasing the risk of cancer. The vanity and cleanliness of the modern woman urges her to keep her teeth clean. She sees the dentist more frequently than do the men. The chief factors in cancer of the mouth are ragged, dirty teeth and ill-fitting plates. These factors are increased by the use of tobacco, even when it is not abused.

The moment the child gets the colic or is constipated, the possibility of appendicitis will be a good subject for discussion. Ochsner, of Chicago, left a rule which will always be valuable—if there is colic or pain in the belly, no harm is done if no cathartic is given, and much harm may be done when it is given. Colic or pain in the abdomen mean *no cathartic!* no food! very little water! and, call the doctor by telephone. Appendicitis in children is rare before 3 years of age, but there is no objection to a parent with the first child learning the methods of preventing or recognizing early the possibility of appendicitis. This is the beginning of knowledge for the future protection from cancer of the stomach, colon and rectum. In these diseases there is always early warning. Immediate examination with x-rays, or with the proctoscope, will reveal the earliest and most curable stage of cancer of the stomach, colon or rectum.

This modern conception of the protective value of periodic examinations, and seeking the advice of a physician or dentist the moment there is warning, is no longer based on theory alone. Study of the cured cases of cancer from 1890 up to date demonstrates that the most essential factor of that protection is a physician or dentist in whom the individual has confidence. In former years those individuals who had confidence in the medical and dental professions reported quickly after the first warning. Periodic examinations while well, came years later. I have personally gone over the histories of most of the records which are collected in the Surgical Pathologic Laboratory of Johns Hopkins University, and have found the evidence to prove the truth of this statement.

The protection of the family by the early life insurance of the bread winner is established. Protection of the individual by the selection of a physician or dentist is also established, but the salesmanship for life insurance is far better than for protective examinations and preventive medicine. The financial reward of the life insurance salesman is greater than at present are the financial rewards of the physician or dentist who urges preventive medicine and examinations.

Someone writing for the New York Academy of Medicine has made the statement that if the medical profession were more successful in presenting the advantages of periodic examinations and preventive medicine, there would be tremendous financial rewards, and this result would probably settle the high cost of medical care. There is every evidence to suggest that the high cost of medical care is largely explained by late treatment. Late treatment is more costly in time and money than early treatment, and for the majority it is the period of disability that is the most costly.

Many are of the opinion that it is *fear* which prevents people seeking periodic examinations or early diagnosis when there is any warning. This may be true. But my own experience and studies suggest the larger army—those who neglect themselves—*is due to ignorance* and not fear. When we have dispelled ignorance, the number of people seeking the advice of physicians and dentists while they are well, or the moment they feel sick, will be so large that those in the army of fear will be carried along with the crowd.

There is no doubt that the dentist and physician must always bear in mind *fear;* should do nothing to increase fear; and should learn how to talk to patients in such way that they will allay anxiety. The modern psychiatrist is busy curing people whose whole trouble is fear. Every member of the medical or dental profession must learn how, during the diagnosis and treatment of any disease, to allay fear, reduce anxiety, and, at least, make the patient mentally and physically comfortable while the disease gets well of itself, or is really permanently or temporarily cured, or ultimately is fatal. There is no disease that tests all the essential functions of the physician and of the dentist as severely as does cancer, and until we discover the cause and the specific cure of cancer, we can save more people from death by cancer—by prevention and by the earliest recognition and treatment.

To accomplish this there must be a definite and better educational program, and effort by both the people and the profession. Meetings of this kind are most helpful. Nevertheless, without the co-

operation of the medical, dental, nursing, and social service professions, meetings of this kind and publicity in the press are but flashes in the pan.

Ultimately, the educational program must be kept continuously alive in each locality. For rural communities, the simplest educational unit is the County Medical and Dental Societies and the Health Department, working with all other educational agents. In the cities, we are beginning to feel that there must be educational centers similar to those in the counties. One has already been established in Baltimore, under the direction of the Health Commissioner of that city, and the School of Hygiene and Public Health of Johns Hopkins University. It is my personal opinion that women—and especially mothers—can be most helpful in bringing about this great protection from diseases, not only in their own homes, but throughout their locality.

Atlantic County

Reported by Mrs. James North

The Woman's Auxiliary to the Atlantic County Medical Society held its December meeting at the home of the President, Mrs. James H. Mason.

It was decided to hold meetings every 2 months at the homes of members. It was also decided to give $65 to local charities at Christmas time.

Tea was served by the officers after the business meeting, and cards were enjoyed.

February Meeting

The February meeting of the Woman's Auxiliary to the Atlantic County Medical Society was held at the home of Mrs. Charles D. Sinkinson, Jr.

Plans were made for a Public Card Party, to be held February 28; and the Annual Spring Luncheon, in May.

It was decided to give to schools throughout the county one year subscriptions to Hygeia.

Mrs. Sinkinson was assisted by Mrs. Baxter H. Timberlake, Mrs. Carl Surran and Mrs. James North as hostesses.

Bridge and Tea followed the business session.

The next meeting will be held in April at the home of Mrs. Joseph Poland.

Bergen County

Reported by Mrs. Harrison B. Wilson

November Meeting

The November meeting of the Woman's Auxiliary to the Bergen County Medical Society was held on November 15, when the members were guests of the Walker-Gordon Laboratories, at Plainsboro.

Mr. Jeffers conducted the inspection of the plant after a very interesting talk, during which time Mr. Jeffers told about the vitamine study in connection with the milk production. The cow is fed properly selected food all the year round; some of which is radiated by quartz light. He explained about the study of vitamine D in relation to milk production: The cow, first of all, must be perfectly healthy and reëxamined thoroughly at stated periods; those taking care of the cows must be healthy and have medical examinations frequently; milk is examined from each and every cow once a week. To watch the operation of the new rotolactor was most interesting.

A delicious luncheon was served in the circular room around which the rotolactor works. The walls of this room are decorated with ceramics showing the history of the milking cow.

A drive through the Princeton campus completed the trip.

December Meeting

The regular December meeting of the Auxiliary was held at the Elks Club in Hackensack, December 13, with the President, Mrs. Joseph Morrow, presiding.

The Corresponding Secretary, Mrs. George Knowles, read a letter from the Society for the Relief of Widows and Orphans of Medical Men in New Jersey. Application blanks for membership in the organization were distributed.

A letter was read also from the National Committee of Public Relations suggesting a community program to be sponsored by the Woman's Medical Society Auxiliary.

A motion was carried to send a Christmas gift of $25 to each of the 4 hospitals in Bergen County.

The guest speaker of the evening was Miss Audrey Grace Adams, of the Borden Company, who gave a talk on "The Nutrition Value and History of Different Cheeses". The fact was stressed that when trying to economize on menus, it is good to know about the nutritional value of cheese as a food.

Refreshments were served.

Camden County

Reported by Mrs. W. H. Pratt

The regular meeting of the Woman's Auxiliary to the Camden County Medical Society was held on January 11 at the home of Mrs. Joseph Roberts in Haddonfield.

Mrs. Lippincott, President, spoke briefly on "False Advertising"; and read an amusing essay on "What the Doctor's Wife Should Know". After greeting the new members, she urged the members to have their husbands join the Society for the Relief of Widows and Orphans of Medical Men of New Jersey.

The inaugural message of the National President, Mrs. James F. Percy, of Los Angeles, was also read by our President.

Mrs. A. J. Casselman announced the Public Relations meeting to be held on February 7 in the club-house of the Woman's Club of Camden; guests from the Philadelphia, Burlington, and Gloucester County Auxiliaries to be invited, also representatives from other organizations in the county. Mrs. Taneyhill will be the speaker.

The principal address of the afternoon was given by the President of the State Medical Society, Dr. A. Haines Lippincott, whose subject was "Legislative Problems Affecting the Public and the Medical Profession". Various questions by the members and the close attention given, attested to the interest which this address created in the audience.

Tea and a Social Hour followed the business session.

February Meeting

A woman should seek no higher aim in life than that of motherhood and home builder, Dr. John M. Fisher, of Jefferson Hospital, Philadelphia, told members and friends of the Woman's Auxiliary to the Camden County Medical Society in an address at the Camden Woman's Club, 424 Linden Street, February 7.

Dr. Fisher declared the theory of equality of the sexes to be incorrect both from a physical and a social standpoint. He deplored "male mimicry" among women on the grounds that it was apt to claim much of their "finer sensibilities and usually spoiled them for future motherhood".

The reduction in the birth rate among families

of "good stock" is, according to Dr. Fisher, cause for alarm concerning the future of the nation. Continuing in a lighter vein, he said that "a new motive for motherhood must be found".

"It is lamentable that old families are dying out. A family of 3 children is considered large today, while in the last generation families of 8, 10 and 12 were common," Dr. Fisher stated.

That only the capacity for developing talents is inherited and not the talents themselves, was stressed by the speaker.

"Every boy in the United States has the opportunity to become President, but not every boy has the inborn capacity to become a successful huckster of cabbages.

It can be said with safety that 50% of the youth attending colleges today haven't college brains. Fools educated at college generally remain fools. Colleges cannot create brains. They can only develop a person's capacities."

Early training for good citizenship was emphasized by Dr. Fisher, who said that prisons are filled with men and women whose parents failed to give them proper training in their early years.

Dr. Fisher was heard by representatives of the Medical Auxiliaries in Burlington and Gloucester Counties, and 7 Camden County women's organizations, including the P.-T. A., American Legion Auxiliary and service clubs, in addition to the Camden County Auxiliary. He was introduced by Dr. Alexander J. Macalister, of Camden.

Mrs. Arthur J. Casselman, Public Relations Chairman of the County as well as of the State Auxiliary to the New Jersey Medical Society, arranged for Dr. Fisher's appearance. Mrs. A. Haines Lippincott, President of the Hostess Auxiliary, presided.

Mrs. Harold Beebe, of Pitman, entertained with musical interpretations. Tea was served by a committee headed by Mrs. Orris W. Saunders, assisted by Mrs. E. G. Hummell, of Camden. Mrs. David Bentley, of Haddonfield, received the visitors, and those pouring were Mrs. Robert Gamon, of Merchantville; Mrs. Gordon F. West, of Colwick; Mrs. William Wescott, of Berlin; and Mrs. John E. L. Van Sciver, of Haddonfield.

Gloucester County

Reported by Mrs. Henry B. Diverty

January Meeting

The regular monthly meeting of the Woman's Auxiliary to the Gloucester County Medical Society met at Oakwood Country Club, near Woodbury, Thursday evening, January 19, at 9 o'clock, the place and time of the doctors' meeting.

The president, Mrs. Downs, not being able to be present until later in the evening, Mrs. Fuller Sherman presided. Members present were Mrs. J. Harris Underwood, Mrs. Ralph K. Hollinshed, Mrs. Bowersox, Mrs. William Brewer, Mrs. David Brewer, Mrs. Fuller Sherman, Mrs. Henry B. Diverty, all of Woodbury; Mrs. Ralph K. Hollinshed, Westville; Mrs. Allan Black and Mrs. Baxter Livingood, Swedesboro; Mrs. L. Thomas Sooy, Pitman; Mrs. Chester I. Ulmer, Gibbstown; Dr. Emma Richardson, Camden, guest.

After the business meeting Mrs. Ulmer kept the ladies very delightfully entertained at various games. At the conclusion of the doctors' meeting we were invited by Dr. Downs to join them in the dining room, where a very tempting collation was served.

The Woman's Auxiliary to the Gloucester County Medical Society held a "Dessert Bridge" at the home of the president, Mrs. Elwood E. Downs, Delaware and Childs Streets, on Wednesday, January 25, at 1.30 p. m. The following members were each responsible for a table and a prize: Mrs. Elwood E. Downs, Mrs. J. Harris Underwood, Mrs. Fuller Sherman, Mrs. Henry B. Diverty, Mrs. C. A. Bowersox, all of Woodbury; Mrs. Chester I. Ulmer, Gibbstown; Mrs. Ralph K. Hollinshed, Westville; Mrs. Baxter Livengood, Swedesboro; Mrs. H. Wilson Stout and Mrs. Thoralf Sundt, Wenonah. Each prize was numbered and a corresponding number was distributed—one to each of the ten tables. The highest score was the winner. A very delightful afternoon was spent together and at about 5 p. m. the ladies bid their hostess adieu.

February Meeting

The regular meeting of the Woman's Auxiliary to the Gloucester County Medical Society was held February 17, at the Oakwood Country Club, Woodbury Heights, with the president, Mrs. Elwood Downs, presiding.

The following members were present: Mrs. Allan Black, Mickleton; Mrs. Ralph K. Hollinshed, Westville; Mrs. T. M. Gairdner and Mrs. Chester I. Ulmer, Gibbstown; Mrs. Baxter Livengood, Swedesboro; Mrs. William Crain, of Woodbury and Mt. Ephraim; Mrs. Fuller Sherman, Mrs. J. Harris Underwood, Mrs. David Brewer and Mrs. Henry B. Diverty, of Woodbury.

After the meeting adjourned a social hour followed.

At the conclusion of the doctors' meeting, which was held at the same place and hour, the ladies were invited to join them in the dining room, where a fine collation was served and greatly enjoyed.

Hudson County

Reported by Mrs. James M. Murphy

December Meeting

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held December 5, at the Y. W. C. A., with the President, Mrs. George M. Culver, presiding. The minutes of the previous meeting were read and approved. The resignation of 1 member moving from the city was accepted and 1 new member was welcomed.

Mrs. Nicholson, Chairman of Hygeia, asked that members renewing their subscriptions would please do so through the Auxiliary.

Miss Buck, of the Red Cross Visiting Nurses' Service, read an excellent report of its year's work, and thanked this Society for aid received.

The President spoke of the death of Mrs. Walter Jackson Freeman, the President of the Woman's Auxiliary to the American Medical Association, and asked that a minute of silent remembrance be observed.

Mrs. Freile reported on the card-party which was held in November, and from which a small sum was added to our funds.

The merits of the Allied Aid Appeal were considered, and it was moved, seconded, and carried, that a donation of $25 be given to this worthy cause.

It was moved, seconded and carried that the Annual Card Pary be held on the afternoon of January 18, 1933, and that tickets would be $1. It was moved and seconded and carried that the regular January meeting be omitted, as the first Monday is a holiday and on the second Monday the open Executive Board Meeting in Trenton will be held.

Mrs. Freile was appointed Chairman of Entertainment, to serve during Miss Hetherington's

illness; Mrs. Charles Kelley to take charge of the preparation and distribution of tickets; Mrs. Harry Perlberg to take charge of reservations; and Mrs. Sirken to take charge of the tea-table arrangements.

The program followed: Scraps of Medical Information, given by members of the Auxiliary. These included humorous incidents, and instructive ones, but the articles read and discussed on the subject of state medicine were the center of interest.

There being no further business, the meeting adjourned and a social hour followed with tea.

FEBRUARY MEETING

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on Monday afternoon, February 6, at the Y. W. C. A., with the President, Mrs. George M. Culver, presiding.

The minutes of the previous meeting were read and aproved.

There was no meeting in January, because the regular meeting day was a holiday, and the second Monday, the Executive Board was meeting in Trenton.

Mrs. Frank Nicholson, Chairman of Hygeia, reported that the 5 subscriptions voted by the Auxiliary, to be placed in institutions of Hudson County, had been sent to: St. Francis Hospital; Christ Hospital; North Hudson Hospital; Y. W. C. A., and St. Mary's Hospital, Hoboken; also, that the subscription (which had been given as a prize, at the January card party), had been sent to the winner.

The president called attention to the tickets for the Jersey Journal Cooking and Home Makers School to be held in the Henry Snyder Junior High School on February 7, 8, 9, 10, all members being welcome.

Announcement was made that our next speaker would be Mrs. Ethel C. Taneyhill (Field Secretary for the N. J. State Medical Society); her subject "You Are What You Eat". Members may have guests by notifying the Secretary.

Mrs. Culver discussed the work of the Executive Board Meeting in Trenton, in January, and reported that the State Auxiliary is now a member of the N J. State Federation of Women's Clubs.

A letter of thanks was read, from the Visiting Nurse's Association, in grateful apreciation of our gift of money.

Mrs. Norman L. Rowe gave a talk on the Y. W. Drive, and it was voted to give a donation of $25. Mrs. William Freile then gave the report of the Card Party, held in January to swell our Charity Fund.

The speaker for the afternoon was Mr. Bernard S. Coleman, formerly President of the Jersey City Health Council and now Director of Relief in Passaic and Clifton. He gave an interesting talk on his trip through Europe, in the interest of Public Health Service. and contrasted conditions over there with conditions in the United States; after his talk, a discussion followed in which Mr. Coleman answered many questions.

Tea and the usual Social Hour were enjoyed and a rising vote of thanks given to Mr. Coleman for his kindness in giving us an afternoon of his valuable time.

Ocean County

Reported by Mrs. Eugene G. Herbener

The regular meeting of the Woman's Auxiliary to the Ocean County Medical Society was held at the residence of Mrs. Harold B. Disbrow, Lakewood, December 2. at 3 p. m., with the President, Mrs. Alfred Woodhouse, presiding, and the following members present: Mrs. V. M. Disbrow, Mrs. Harold B. Disbrow, Mrs. Alfred Woodhouse, Mrs. Frank Brouwer, Mrs. E. G. Herbener, Mrs. Frank Denniston, Mrs. Blackwell Sawyer, Mrs. Adolph Towbin, and Mrs. J. L. Lane.

It was decided that each member give a card party at her home and the proceeds be given to the Paul Kimball Hospital, all returns to be forwarded to the Treasurer, Mrs. Blackwell Sawyer, Toms River, New Jersey, by March 1, 1933.

It was agreed that the next meeting take place on the first Friday in May 1933.

A vote of thanks was extended to Mrs. Harold B. Disbrow by those present for the refreshments served, and very pleasant afternoon spent at her home.

A motion to adjourn was approved.

County Society Reports

ATLANTIC COUNTY

The regular monthly meeting of the Atlantic County Medical Society was held December 10, at the Chalfonte Hotel, with 48 members and guests present. The minutes of the January meeting were read and accepted.

Dr. Silvers reporting for the Board of Censors that Dr. George Schwarzkopf's application had been accepted, he was elected an Active Member.

Dr. Darnall, for the Library Committee, reported progress.

Dr. Carrington, for the Post-Graduate Education Committee, reported that there would be 2 Courses, 1 each in Medicine and Neurology. The medical course starts Wednesday, March 1, and will be held in the Nurses' Home, at 1907 Pacific Avenue, at 8.30 p. m. The Course in Neurology will start the Wednesday immediately following the last lecture in Medicine, and will be given by Dr. Spiegal.

Dr. Conaway, reporting for the Broadcasting Committee, stated that it would be impossible to have the same time each week, as heretofore, but that the time could be arranged to suit both the station and the speaker, and asked that members who would give talks get in touch with him to arrange for their time.

Dr. Irvin read a letter of appreciation from Dr. Gustav Gehring, for the honor bestowed upon him in making him an Honorary Member of the Society.

Dr. Shivers appointed the following members to the Maternal Welfare Committee: Drs. N. J. Quinn, Chairman, Joseph Poland, and Myrtile Frank.

The first paper on the Scientific Program was presented by Dr. Barton Cooke Hirst, Emeritus Professor of Obstetrics, Medical School of the University of Pennsylvania and Professor of Obstetrics and Gynecology, Graduate School of Medicine of the same University, on "The Best Means to Further Reduce the Maternal Mortality of Childbirth".

According to accepted opinion we occupy an inferior position in an international comparison of the mortality of child-birth. We are not so bad as a mere statement of figures without analysis would make us appear, but we might, and should, have a better record. What is the matter with us?

(1) The practical training of our medical students is still defective, though vastly better than it was a generation ago.

(2) There is a lack of uniformity in the teach-

ing of obstetrics; in sharp contrast with Europe, where a standardized method prevails in all the schools of each country.

(3) There are too many hospitals poorly equipped and constructed, with lack of adequate technic, and a lax enforcement of such aseptic regulations as may have been promulgated, but are too often disregarded, especially in "open" hospitals.

(4) There are too few hospitals with adequate provision for the rigid segregation of patients with infection.

(5) There is too often inadequate pre-natal care, both in home and hospital deliveries, but especially in the former; this was the case in more than half the deaths from toxemia in Philadelphia.

(6) In our mixed, polylingual population, ignorance and neglect on the part of the patient herself are responsible for some of the fatal results.

(7) We have too high a percentage of operative deliveries.

(8) The assumption of responsibility in complicated cases by the general practitioner without special training, contributes its share to the mortality rate.

(9) The hospitalization of maternity cases, progressing with amazing rapidity, appears to be an important factor. It is said that ⅔ to ¾ of the women in large urban centers are now delivered in hospitals, and this proportion promises to increase steadily. A recent survey of Philadelphia, made by myself, shows that we have now enough hospital beds set apart for obstetric patients to accommodate every one of the 33,000 women delivered in the city.

The statement that hospitalization apparently increases maternal mortality is at first sight disappointing. For years I have advocated the hospital as the place to improve the prospects of the expectant mother. The better equipment, better opportunity for real asepsis, the trained staff, all should argue for better results, but, if we are to be influenced by figures alone, a sad disillusionment awaits those who believe the hospital insures a greater safety for the child-bearing woman. In a survey of maternal deaths in Philadelphia, conducted for more than 18 months by a committee of which I am a member, the maternal death rate in child-birth has been 6 times greater in hospitals than in the homes!

An analytic study of the mere figures puts, however, quite a different aspect on the matter, and leaves me as strong an advocate for the hospitalization of maternity cases as I have ever been. It is well known that the hospital receives more than its share of "bad cases", of emergencies, and of women who will, presumably, develop complications. Most of the severely infected women, who furnish much the highest number of deaths after child-birth, are transported to a hospital. It is true that infected women in a hospital may endanger the other patients, if the infection is allowed to spread, as has been lamentably manifested in some recent instances, but such occurrences are easily avoided if the management of the hospital is what it ought to be in respect to asepsis, nursing, laundry, general hygiene, and, if its construction permits, the isolation of infected patients. Unhappily, this is by no means always the case. To show what can be accomplished, however, in the limitation of communicated infections, the Lying-in-Hospital of Philadelphia, in more than 2000 deliveries last year, had only 2 deaths from infection; a death rate of .001%, and in neither of those patients had the infection been transferred to another patient. One woman died from septic peritonitis after a cesarean section, and the other from pyelonephrosis.

There is one valid criticism of hospital practice. *The incidence of operative deliveries is too high in all of them, good and bad.* But, how easy it ought to be to avoid this fault, and how perfectly practicable it should be to insure a proper construction and regulation of these institutions to prevent the only real danger of hospital deliveries —the spread of infection. It might be desirable to have official inspections, such as the American College of Surgeons has made of general hospitals, and to give recognition only to those complying with sensible requirements.

I realize that I have presented this subject incompletely and inadequately. But if it leads to an investigation of conditions in this community by a "fact-finding committee", and if it should appear, as is unlikely in your favorable environment and with the character of the profession here, that some improvement could be effected, I have accomplished the purpose I had in mind in accepting your very kind invitation to take a part in the proceedings of this evening.

Discussion

Dr. N. J. Quinn: I am sure there is not much discussion possible, as Dr. Hirst certainly gave us a matter-of-fact, common-sense summing up of what has been in the minds of a great many men practicing obstetrics. There have been a lot of silly ideas brought out in the lay magazines recently on this very important subject. I have read a number of articles, back and forth and pro and con, and I am surprised how we stand by and take the judgments passed upon physicians by lay writers who possess no knowledge of obstetrics.

I don't think we should discourage hospitalization. The fact that we have some deficiencies in the hospital is no reason why we should have them stay at home. The time is coming when delivery at home will be as obsolete as an appendectomy at home.

Are the women of today less fitted for child bearing? It seems to me that civilized man is not attracted to the *maternal type.* We are attracted to women who are less fitted for child-bearing. Civilization is doing something either to man or woman.

According to De Lee's standard, our hospital is wrongly constructed: the delivery rooms and wards, are on the same floor as the operating rooms, and just below the laboratories; yet on reviewing our service records we find that a case of septicemia is rare and the maternal mortality rate is low.

Practically every woman we see, shows, on vaginal examination, some latent infection of the vaginal tract, and I believe we must be more particular in our instructions on feminine hygiene— which now rests almost entirely with the advertisers of various antiseptic solutions.

I saw today a communication from the Venereal Disease Bureau, requesting permission to address the boys and girls in High Schools and Vocational Schools. I believe that is a fine thing to do, and also, that we are just about 25 years behind times. I think we should give the public some more definite ideas of feminine hygiene.

Dr. W. J. Carrington: Bearing out some of Dr. Quinn's statements, I have some figures that may be of interest.

De Kruif's article said that any hospital or any physician who is known to have had a case of puerperal septicemia should be boycotted. I believe that is ridiculous.

In 1930, in our city there were 1233 births; 847 in the hospital. In 1931, there were 1220 births, with 995 in the hospital; and in 1932, there were

1106 births, with 926 in the hospital. This is a total of 3539 births, with 2768 in the hospital, and in those 3 years only 10 women died in the hospital and only 2 of these were due to puerperal sepsis. There were 23 cesarean sections, with 3 deaths.

In so far as obstetrics is concerned, our hospital is open—any physician can deliver any private patient, and it is only recently that a rule was made by the Staff, that before any operative procedure can be done a member of the Staff must be called in consultation.

Dr. W. E. Darnall: I was rather interested in Dr. Hirst's statement about the high mortality in ectopic pregnancy, in Philadelphia. I think our local profession must be better than that in Philadelphia, because we rarely lose such a patient. When they are sent in promptly they get well, because we operate promptly.

One of the things bringing our mortality down is our changed idea with regard to toxic conditions. Formerly, a patient with eclampsia was operated on the first thing, but now operation is not done until everything else has been tried. I think, too, that if we knew the whole truth about the patients delivered in private homes, we would find the hospital mortality rate lower by comparison than now appears.

Everyone is more or less aroused about maternal welfare. Even President Hoover called a session together to go over the whole field and this has given greater impetus to the societies who are making surveys.

Dr. W. P. Conaway: I hope our members will consider such an investigation as was proposed by Dr. Hirst. That was food for thought.

The second paper of the evening was presented by Colonel Fred A. Fenning, of the Washington, D. C., Bar, General Counsel and Honorary Member of the District of Columbia Medical Society, who gave a very interesting address, tracing the doctor's contact with the law from the time he must get his license to practice medicine and have it registered. Some of the phases he touched upon were the recording of births, reporting of contagious diseases, suits for malpractice, committing a patient to a mental institution and later releasing him when he has recovered, witnessing a will and signing a death certificate.

BERGEN COUNTY

C. H. Littwin, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held at the Oritani Club, in Hackensack, February 14, with Dr. Alexander presiding. This was known as the "Economic Meeting" and after routine business was transacted the Chairman announced that we had as guests Dr. David J. Kaliski, Retiring-President of the New York County Medical Society, and Dr. Samuel J. Kopetzky, Editor of "The Medical Week" and a Past-President of the New York County Medical Society.

Dr. Kaliski presented an admirable paper on "The Present Day Status of the Medical Economic Question" with especial reference to the Report of the Committee on Costs of Medical Care.

Dr. Kopetzky spoke on the question of "Group and Contract Practice".

Discussion of both these papers was opened by Dr. J. B. Morrison, Secretary of the Medical Society of New Jersey. He called special attention to the Abstract of the Committee's Report in the January issue of our own Journal. Dr. Reik explained the Editor's object in collecting and editing the material for the January Journal, and stated that, with the information contained therein placed at his command, each member of our State Society has all of the essential facts necessary for the formation of his own conclusions and recommendations—and can start at par with the members of the above named national committee.

A member of our Special Committee to Study the "Report of the Committee on the Costs of Medical Care", having admonished a group of our members for not having read that "Report", and urged that each of them should purchase a copy of the book—Medical Care for the American People—Dr. Reik "turned the tables", on behalf of those members, by "kidding" the committeeman—saying, "he has made it patent that he has not read the January Journal, which had for one of its specific purposes the supplying of that book's information and removing the necessity for its purchase".

Dr. Littwin commended the January Journal to his associates and stated that he had read the book first but understood it better after reading the Journal; the abstract having made the full Report more easily understandable by virtue of the abstracter having re-arranged some of the facts in a more logical and orderly sequence.

BURLINGTON COUNTY

Joseph M. Kuder, M.D., Reporter

A special meeting of the Burlington County Medical Society was held at the Burlington County Hospital at Mount Holly, Thursday evening, February 2, at 9 p. m.

The meeting was called to order by Dr. John S. Conroy, of Burlington, Acting-President for this occasion, and was devoted to a consideration of the Majority and Minority Reports presented by the National Committee on the Costs of Medical Care.

Dr. Conroy opened the meeting by introducing the guests, as follows: J. B. Morrison, Secretary of the State Society; A. C. Morgan, of Philadelphia, and a signer of the Minority Report; F. E. Procter, President of the Mercer County Society; A. D. Hutchinson, Secretary of the Mercer County Society; James Fisher, District Councilor, of Asbury Park; W. G. Herrman, member of the Board of Trustees of the State Society, of Asbury Park; Drs. Franklin and Fesler, of Trenton; J. L. Edwards, of Riverside; Mr. Heffinger, Superintendent of the Mercer Hospital, at Trenton; and E. C. Steinsieck, of Burlington.

Dr. Conroy: This is a *Special Meeting*, and there will be no regular routine, such as reading of the minutes. The object is, not to vote one way or the other on this Report of the Committee on the Costs of Medical Care, but to bring certain facts to our attention, and I hope every one present will feel free to join in the discussion.

We are fortunate in having with us, Dr. A. C. Morgan, who was a member of the Committee and a signer of the Minority Report, and I am going to ask him now to talk to us.

Dr. Morgan: In explanation as to how I came to be associated with this Committee, I will say that when it was formed, in 1927, I was President of the Pennsylvania State Medical Society. I have enjoyed all the time I have spent on the Committee, and all that we got out of it, gentlemen, was our car-fares, our hotel bills, and our "eats". There was no graft and no emoluments. This Committee

was not sponsored by President Hoover, though there was another Commission, appointed by the President, which worked for some years on this subject.

At first, Dr. Wilbur was Chairman, and he delighted my heart in the way he lauded and put in the forefront the family doctor; and for at least the first year, at all our meetings, the family doctor was always put before us, with stress laid upon his importance, and that all of our studies must revolve around him. Time went on, and we began to receive reports of the research work which was being done. Then we began to hear of sections, cross-sections, and personalities, so that in the end, instead of the family doctor, my impression is, that he has proved to be "the forgotten man" to the Committee on the Costs of Medical Care. It was because of this fact that the Minority Group was formed, and began to assemble themselves. We saw, or thought we saw, a trend toward the cold, calculating research and classification of the entire study; so, we banded together and developed the Minority Report.

At Atlantic City, on December 10 (Dr. Morrison was there), Dr. John Hartwell, of New York, expressed the thought that if there had been a council and a "get-together" meeting, the differences could have been ironed out and there would have been nothing to differ on, and therefore only one "Report". My reply to that was as follows:

When the first draft of the Report was submitted, in December 1931, the Minority presented many objections and points for correction, which were adopted and read into the other report. Then, as time went on, Dr. Christie, of Washington, presented a paper, and his paper was adopted to replace a certain chapter and section of one of the final reports. In July, 1932, Dr. Van Etten, of New York, was made Chairman of the Committee to determine and express, in concrete form, the relation between physician and patient. Up to that time all of those figures and reports had ignored or overlooked the family doctor. You will find that there is very little in the report which refers to the family doctor. On page 168 you will find in the Minority Group report, which was not adopted until September 1932 (the "final report" was adopted in November 1932) a paragraph which supports the contention that the family physician was overlooked and no mention had been made of his relationship with the patient.

Dr. Hartwell said that these differences could have been ironed out. On the many occasions when the Minority Group met, we went over every word of the report, and we spent a good many hours of one day in Washington going over the final draft of the "Report". It was suggested that our Report might be merged with that of the Majority Group, but we said "No"—that we wanted our expression of opinion to be incorporated "as was" and not to be mal-assimilated with the Official Report. That explains why we of the Minority Group presented our report. It is not that we are not in accord with the general study. The Minority Group accedes to many of the recommendations of the Majority Group, but we are in favor of the professional relationship existing between doctor and patient continuing. We are opposed to anything which will disturb or disrupt the existing state of things whereby the doctor received full valuation for his services; for instance, such as has been tried in some of the Philadelphia hospital-insurance schemes, etc., which have been practiced during the last 2 years, but which were unsuccessful because the Philadelphia County Medical Society did not sanction them, and neither were they sanctioned by the American Medical Association.

Their criticism of us is that we have no counterplan to offer as a substitute—but we have. We want things to continue as they are, and not to allow the reformers, the economists, the research workers and the idealists, to legislate for the profession. We are of the opinion that in the readjustment of our own profession there is plenty of brain capacity to work out our own problems without help from any other group, and to have these reformers force themselves upon us is repugnant and obnoxious to the medical profession as a whole.

Last week we were advised that 98% of all the Medical Society publications have been voting in favor of the Minority Report, leaving only 2% of the news-papers and medical societies in favor of the Majority Report. The New England journals, especially, have been very strong in their advocacy of the Majority Report, and they are probably back of that editorial which has been distributed widely from Washington in support of the Majority Report.

Now, how shall this change be accomplished—this change which we know is coming, and which we must meet? By starting just as we are doing here tonight with, first, the individual doctor, who should have a mind of his own. He has a brain of his own, but that is entirely different from a mind of his own. When we come, then, to group thought, this is not Burlington County here tonight. It represents several counties, or nearly 1/3 of the State Society membership. It means that we must get together and finally determine what is the best thing to do for the medical profession in this special section of the United States. We are not called upon to legislate for Texas, or California, or for New Mexico—not even for Pennsylvania. You are now holding to "state rights". You may get suggestions from other sections of the country, and if they are good and they appeal to you, you are perfectly entitled to try them out for yourselves; and the schemes which have been tried elsewhere are worthy of your consideration. Then you may either adopt one or two of the plans, or you may take the best of them and make a working formula so that by trial and error you, in this section of the country, may be able to work out the problem which confronts the medical profession here, for your own salvation; always remembering, however, the importance of the relationship between the physician and the patient.

Personally, I refrain, in my talks, from expressing opinions that are Morgan's ideas, for this reason—Morgan is asked to appear before many societies, not to tell what Morgan's thoughts or plans are. No. In a round-table discussion, or the like, yes, but I am not invited to speak for Morgan. I am invited to tell you how the Committee came into being, and how we ran along parallel lines, in many instances, with the Majority.

You New Jersey physicians will have your State Society meeting in June. The A. M. A. will meet in Milwaukee June 12 to 16. Pennsylvania, in October at Philadelphia. Now, the concrete thought, starting from the individual doctor, then the County Society, then the State Societies, will, I am sure, come to an agreement which shall best represent the matter for New Jersey, or for any other State Society. There is a big job, and it is incumbent upon your State Society officers. I heard Dr. Morrison discuss this December 10 at the Tri-State Conference. Dr. Morrison is well-advised and well-informed and is a fitting leader for you men at your meeting in June. I am sure that at that time the 21 counties of New Jersey will come to a satisfactory set of resolutions which shall represent your best thought. That doesn't mean that your decision there must be the final one. Try out

some of the schemes and, then, if they don't succeed, scrap them and try others. In this way you will come to the proper solution.

Every doctor must feel his responsibility in this matter. There is much talk about *state medicine,* but, for a group of men to say—"You must accept state medicine because we think that is the best thing for you"—that doesn't go down well with doctors. We are a group of individualists, and we cannot be handled in the mass by men using such tactics. However, we must be resourceful in our progress and in our movements. If we simply come out on a negative phase all the time, it isn't so good. Mr. Clark, of New York, has issued a new book on this subject. I understand that in the first draft of this book he was an arch-advocate of social movements. Since this report was mentioned, however, Mr. Clark has modified his statements a good deal, although one of his recent expressions is—"If the medical profession and the A. M. A. want a fight, they can have it." Now, that is Mr. Clark talking, but that isn't the whole thing. Mr. Filene is the only man who appeared before the General Committee meetings in Washington. He has retained Mr. Clark, and also Mr. Cook, of Philadelphia, to be his co-workers in a new scheme which they are promulgating.

Of the editorial comment in news-papers and current periodicals, 98% show that the arguments and talks of the Majority Group have not struck a responsive chord among the common people of this country. The American Medical Journal of about December 17 carried a summary of these reports, all of which were quite favorable to the Minority Group. They tell of this and of that, and the Philadelphia Record wound up by saying—"We will not take State Medicine." In the present issue of the Ladies Home Journal there is, on the editorial page, quite an article, in which it is stated that the Minority Report is going to prevail. The January number also contained an article which is worth preserving.

Now, where there is a settlement or a big industry far away from hospitals, there is no objection to the Company providing care for its people, because they are far from the beaten path. These things are only temporary, however. One of the things I have in mind is the Hoover Dam. In a few years, the settlement there will be gone. It is entirely proper for them to be under contract guidance and care. In other cases, however, where there is close proximity to hospitals and doctors, we do not like that kind of thing. It implies that doctors are hired to attend the insured only, and such service does not appeal to the general masses, nor to physicians.

I wish to call your attention to the Bulletin of the A. M. A. Every one of you *receive* it, but whether or not you *see it* is an entirely different proposition. The December number of this periodical is a very valuable one to read, in that it defines what constitutes good and bad contract practices. Unquestionably, the best State Medical Journal, in so far as its attitude toward the economic phase of medicine is concerned, is the Illinois Journal. I am not trying to sell the Illinois Journal, but I would recommend that every Society shall subscribe to that Journal, through its Secretary, and let him hand it to the Committee on Medical Economics. In that way, I am sure you will get lots of "food for thought" which will well repay you.

As a corrollary to the Majority Committee Report, I hold in my hand a clipping from the A. M. A. report of December 1932. In this Report, signed by 3 members, we find some interesting excerpts, and in this report the doctor comes into his own. He is retained and maintained in his proper perspective, as to the proper relationship between doctor and patient.

In respect to the foreign studies in the January number of the New Jersey State Journal, you will find there a report of the Tri-State Conference held in Atlantic City, on December 10, by the Secretary of the Conference. Dr. T. C. Routley, General Secretary of the Canadian Medical Association, discussed medical problems as existing in the 9 provinces of Canada, and gave a sketch showing how they applied in each state, and he argued for *state medicine.* One of our workers who has been especially active in the American Dental Association is Dr. Sinai, who was sent abroad and made rather an extensive study on the Continent. He studied conditions in Germany, France and Russia, with the result that his findings are directly opposite to the paper presented by Dr. Reik to the Tri-State Medical Conference. The Bulletin, discussing conditions as applying to compulsory health insurance in Germany and in England, shows that all is not well. Therefore, instead of permitting a thing like that to be put upon our books, it is well for us to heed that sign—"Stop, Look and Listen."

I have now said enough in respect to the background of the Minority Group. I always like to have time for a round-table discussion, and to invite questions, so that we may learn and profit by your discussions. Then as you bring out those discussions, the thought gradually centers and goes into the solution of your own problems, and that is our whole importance, in this Minority Group—to put the matter before you and let you decide. We did not feel that we were justified in making recommendations, as we do not represent the American Medical Association. We happen to be members of the A. M. A. but, as I said before, Morgan is only a member of the Philadelphia Medical Society, and that is all Morgan wants to be—simply a doctor, with you, who had the privilege of joining with this Committee, now out of session, and Morgan is now back in the ranks of the doctors. I thank you.

Dr. Conroy: We are very grateful to you, Dr. Morgan, and I would now like to have a full discussion of this question. May I ask that you first give your name, so that the Secretary may identify you for recording your remarks?

Dr. Hyman I. Goldstein: I am not going to discuss the Majority Committee Report, and I am certainly not going to put myself in an embarrassing position by trying to discuss the Minority Report when a member of the National Committee is present.

You know that banks are still closing their doors in spite of the fact that 50% of them have received assistance from the R. F. C. If, after this vast amount of Federal expenditure, conditions still remain the same, the very same thing would happen with any scheme of socialized medicine, even if subsidized with Federal money. In addition to that we should certainly be taxed in some way, shape or form, as when these insurance companies take a hand, they will bear enough influence to get taxes to defray shortages, and every working man will have an additional tax to pay. In these days of speedy legislation, and a host of other things, it does one's heart good to come among a group like this, and, therefore, I take delight in addressing you tonight.

This question of whether we should or should not have state medicine is not the question at all; as we already have plenty of state medicine. The question for you men to decide isn't whether we

should or should not have state medicine, but whether we should have *more* of it. We have the Health Departments, we have the Employees' Liability Insurance, we have the Veterans' Bureau which is treating thousands of men who are not entitled to free service, and who are not suffering from ills directly resulting from the War, and who in many cases are able-bodied men. Then, we have school medicine, with school nurses and doctors. We have corporation medicine, and we have nurses (and this is not in the slightest a disparagement of the nursing profession) who are doing medical work and practicing medicine illegally.

Then we have the fact, that superintendents of hospitals are actually going around advertising for patients in order to increase their work. We have hospitals which started out by filling their own prescriptions, and still do so under a "charity" label, but some of these hospitals are reporting very good profits from this. We have hospitals, also, which have gone into the optical business. Instead of referring their patients to opticians to fill prescriptions, they have gone into the optical business for themselves. Such conditions are occurring right in the city of Philadelphia. I mention this to open fields of thought which perhaps have been under cover long enough.

You heard Dr. Morgan tell us that 98% of the various State Journals have acted and have editorially assumed a policy in favor of the Minority Report. It is regrettable that in these times of depression, when we have a fairly high-paid Secretary with a considerable office expense, allowing plenty of time for study, when this State Journal represents some 2000 or more members, that we should not have a definite editorial policy for the New Jersey State Journal. The Journal, however, has missed an opportunity to be a leader, in that it has failed to assume an editorial policy. The New Jersey Legislature is meeting now. Many meetings have already been held by non-medical groups, at which definite results have been acted on and approved, and yet we are led to believe that we doctors should not be given the privilege of a definite and well defined policy in our own Journal. What good will an editorial policy do next July or August, after the New Jersey State Society meets? I deeply regret that at this late date there isn't a word in print or by word of mouth whereby the Editor of the Journal has assumed a definite policy.

I took a few minutes at a meeting recently to tell of my travels in Europe in 1929, although I was not a paid worker. In 1931, I was there again; and, once more, only a few months ago. So that I know something of the practice of medicine in Austria, Hungary, Czecho-Slovakia, etc., and let me tell you, those men are suffering. We are told in Dr. Sinai's book of the beneficial effects of state medicine, but they don't tell the whole story. The reason the doctors have not fought, is because they are so discouraged that they are scared to death to fight this movement. They wouldn't know where the next meal would be coming from if State Insurance were taken away. What do you suppose would happen to us good doctors if the State Legislature should pass acts legalizing state medicine, and then we found this so-called noble experiment to be a failure? How would we get rid of it? What would happen after 6 or 8 years of this type of medicine? I think that if we looked around and mended our own fences, the doctors would not be appealing for help. There are 2 sides to this question—the question of helping the needy sick people, and also the question of the hard pressed doctors—and we are here to express our own family troubles; since the social workers have certainly not negiected to express theirs.

Now, let us go to the Mid-West—the Iowa State Journal. They do not wait untii next July or September. They present both sides of the question, but they also have the courage to take an editoriai stand, and to help these little County Societies think for themselves.

As to that New England report, to which reference is made by Dr. Morgan, this report is published by the Endicott Johnson shoe factory, perhaps the largest one in the world. I hold in my hand a survey of the report of this corporation, in which we are told that $900,000 was spent for workers' medical service; and then, in one of the paragraphs, it tells you, incidentally, that the full time of more than 100 persons, including 28 physicians, nurses, etc., were employed, and the sum of $161,000 went for actual medical service. Then they teli us that there were 87,500 house visits, and 120,000 office visits, or a total of about 210,000 visits, on which only $161,000 out of $900,000 was spent.

Now, let us go to our own pockets; to the nurses, for whom I have the highest regard. How many doctors are deprived of income by work being done by people who are not licensed to practice medicine? Our nurses are permitted to do the serious job of anesthesia. I think it is more serious to put a patient under an anesthetic than it is to open a boil. Why can't a doctor be taught to do this? Why has a nurse been given the privilege of sewing up wounds? Nurses examine children, and make diagnoses in the schools; there is no question about it. They make recommendations as to what particular doctor should be consulted. Furthermore, we are told that in Camden County the nurses in the schools drag their patients around to men who are willing to take $15 or $20 for an operation. Why should a nurse assume the privilege of the doctor in advising to which nose and throat man that child should go? We have even had a nurse take a child from Camden to a Philadelphia hospital, for examination. We have had a nurse urge and recommend that every school should install fluoroscopic apparatus, so that the nurses could engage in this type of work also.

I want to close by stating that it was a great pleasure to be here tonight, and I hope that everybody will take what I said for calm consideration, because I spoke as I thought and felt. If social medicine becomes a fact over here, then woe to the American doctor.

Dr. Morrison: Members of the Society, and guests: It is now nearly 10.30 p. m. and we have had no general discussion of this subject, so I propose to take not more than 10 minutes of your time. I have condensed my talk into a short manuscript, in order to give it briefly and without waste of time. The officers of the State Society are making an effort to put this before the profession in the most practical way. This is the third County Society where we have had the pleasure of hearing this question presented.

In the discussion of this question, the officers of the State Society are careful *not* to impress their own ideas. You have brains, and we want you to do the thinking, and that is the reason why the Editor of the New Jersey State Medical Society Journal did not state any definite policy on this question. He has published in our January Journal the finest and most comprehensive contribution regarding this question that I have read or heard of, so that we might have in hand information, covering all of the important facts available, to study and then construct our own conclusions. If

County Society members follow that course, and each County reports for its members at the Annual Meeting in June, the result will be the policy that the State Medical Society has developed—and for which the Society will be greatly indebted to its Editor.

(Dr. Morrison's paper, as read at this meeting and at some other County Society meetings, was designed to stimulate discussion, and he prefers to with-hold it from publication for the present; his intention being to submit it, together with a report of his experiences in these county visitations, at the State Society Meeting.—Ed.)

Dr. Conroy: Thank you, Dr. Morrison. I am now going to ask for a general discussion of this subject.

Dr. Mulford: It seems to me that the previous speakers have touched upon most of the points that should be brought out, and I think especially the summary that Dr. Morrison brought out, at the close of his remarks, certainly pertained very closely to us here in Burlington County.

I confess that I have not had the time or opportunity to study these Reports in detail. It was my privilege, however, to be at the Tri-State Conference in Atlantic City, in December, when these gentlemen delivered the addresses which are reported in our Journal, and also to hear Dr. Morgan elucidate the Minority Report. I also heard Dr. Hartwell analyze the Majority Report.

There are many things you have heard tonight which apply to every one of us. As Drs. Morgan, Goldstein and Morrison have brought out, we need an active working Committee to sift out the good and the bad, and to take down to our State Society in June our own definite ideas as members of the Burlington County Society, pertaining to this question of medical economics, and this organization's report should show just what we are going to do here in Burlington County for the care of our own people. It does seem as if our problems differ in a great many ways from the problems of many of the different states. You have heard tonight that California has organized many of these groups. It was my pleasure to go through that state with the Secretary of the A. M. A. Committee for the Study of Hospitalization, and we got a very clear idea of the work as it was being carried on in California, in Oregon, and in parts of Texas and New Mexico. Although there isn't a group in every county, they were being organized very rapidly, under the guidance of the State and County Medical Societies. Under their plan, however, I fail to see how the individual family would be protected and cared for. The 5-year program of this Committee covered many angles of our work. I happen to have a copy of that plan, and I find that the Final Report is entirely different. I think even the public would have rebelled at the original report, as some of this work was financed by the various Foundations. Something seems to have happened to the "powers that be" and it seems to me that the Final Report given by the Committee was very hastily and carelessly written. The resolutions which they adopted come mighty close to us, and it practically wipes out the sacred relationship which has existed between the doctor and the patient.

Before closing these remarks, Mr. Chairman, I want to direct Dr. Goldstein's attention to the Editorials in the January Journal, where Dr. Reik, properly and quite satisfactorily, explained why he did not presume to pose as a *leader*. If the State Society fails to formulate a policy, it is no fault of his.

Note: The President, Dr. Conroy, inquired of Dr. Newcomb, our State Assemblyman, if any bills pertaining to this question had been presented before the present session of the Legislature. Dr. Newcomb replied that up to the time of the present Society meeting there were no bills of this type up for consideration.

Dr. Proctor: We, who are here from Mercer County, are thankful to the Burlington County Medical Society for inviting us. As a Society, we have not yet taken up this Report in detail. In fact, that is largely the purpose of our visit—to gather ammunition. We particularly, of course, wanted to get Dr. Morgan's views, as he is a member of the National Committee. Some of us have read the Report, and our views have crystallized to some extent, but I cannot speak for my Society so far as its views go. However, there are some points in the Report, particularly the method which was undertaken in classifying the regular doctor's expenses and the expenses of medicine, which we might say came from the "lunatic fringe" of the profession, as Theodore Roosevelt used to say, when referring to chiropractors, etc. The possible results implied that that portion of medical expense would not be continued, if these recommendations were carried out, and of course that is nonsensical.

Another thing which we have got to keep in mind is that the original Report took a far more radical view than the Final Report, and the rapidity with which the backers of the Majority Report formed a new Committee to keep their views in front of the public, indicates that they evidently have capable financial backing. To my mind, this presumes that the more moderate tone of the Majority Report will not be continued after they get under way, but that they will probably incorporate some of their more radical plans.

I think that we should decide on our views at the State Medical Society meeting, and adopt a plan to place them in front of the public, and keep after them, just as those who favor the Majority Report are evidently prepared to do, from some of their statements. Our interest, of course, is very intent on this question. We doctors do not get together unless we have something of importance to discuss, and that is the reason, I believe, that there are so many of us here tonight.

Dr. Conroy: Thank you. Dr. Proctor. Now, I would like to hear from Mr. Heffinger, who is Superintendent of the Mercer Hospital at Trenton.

Mr. Heffinger: Although I am not a doctor, I came here for very definite reasons. I am a member of the New Jersey Hospital Association and it was interesting to me to find that this question came up at a recent meeting, as to whether we should include in our program for our next State meeting, a discussion of this Report, and the opinion was that it was too vast a problem for us to attempt to discuss, before we were able to collect some of the opinions of the medical men who are so much more deeply interested. The hospitals, I gather, are going to sit still and wait and see what the doctors think of this Report before we begin to consider what we should think about it. That is why I am here tonight—to find out what you doctors think of this question.

Dr. Curtis: One thing which came to my mind as I read the articles on this Report, and that is,

that we must recognize that the handwriting is on the wall, and we must do something constructive about it, but we must realize, too, that we have got to be cautious and not put the thing across as something that is for the doctor only. We must let the people see that we are doing it for them as well as for the doctor. That we have the patient foremost in our minds.

Dr. Conroy: Would we be honest, Dr. Curtis, when we say that we have the patient foremost in our minds? We certainly want to consider the patient, but we must consider ourselves. I think we are rather on the defensive here, and I think that our fight is to combat this evil.

Dr. Morgan: I don't believe, or I don't think, that that Majority Report is all for the patient. You don't have the relationship of the individual with his doctor, and I don't think that he will get as good service. I admit that this question is also for us, and of course that is what we are here to talk about, but we don't want to put anything over on the public.

Dr. Thorne: I hesitate to say anything, but I am rather surprised at the attitude taken by some here tonight. I don't believe there is a doctor present who feels it is for the best interest of our patients that we accept *state medicine*. I believe that the best interest of the patient is for us to continue as we are doing, if we have any right to self-respect or if we have any right to ask our patients to respect us. I hope we will not accept a program which spells defeat at its very beginning. I hope that we will stand firmly against state medicine just as long as we can.

Dr. Morgan (closing the discussion): I will answer Dr. Conroy's suggestions first. The care of the patient, as discussed in the Majority Report, reminds me of the mannequin which is used in the teaching of nurses. It is in the exact form of a patient—but it lacks blood. The doctor and the patient must work together, as the patient is the life-blood of the doctor. The doctor has the education, he has the training, he has a desire to serve, but if he isn't permitted to serve, then he lacks the life-blood, and the doctor in the last analysis works with his heart, and his heart controls his brain, as he works for the best interests of the patient. I cannot sense from any groups where I have been since this Report came out, where they have had the idea of the dollar before them.

The Minority Group criticizes, or points out, that many of the studies which were used by the Majority Group were studies that had been made under the most favorable circumstances; or, in other words, they put the good apples on top.

In reference to the Canadian situation, I wrote to an old student of mine who is in Saskatchewan, and I got from him an entirely different picture.

Regarding the early drafts of the Report, these were gotten out in April. The one which was finally acted on in November, 1929, contains such raw criticism of the medical profession that it makes one think that they wanted to scrap the doctors who had not been near a graduate school during the past few years. The point is, that in the first draft there was much raw criticism by unthinking men.

I remember that it was suggested to our revered late President Coolidge, when his father died, that he put up an elaborate monument in his memory. But Coolidge said: "Why no. We don't want anything better than our neighbors have in this burying ground."

Suppose it were a fact that Vermont is in need of better medical facilities. Don't you think Coolidge would have found a way in which they could have been obtained? Vermont is getting the medical care which Vermont wants.

Dr. Morrison has given you, in 12 minutes, the product of many years of his study of this question. He has reduced that study to a paper, and don't you see that he, as one of the leaders in your state, has sensed the thing properly, and the guiding hands of your state are taking this matter into consideration?

I would like to remind Dr. Morrison that the Minority Group refrained from presenting any plan, as we did not feel authorized to do so. The keynote of our recommendation is exactly stated by you, sir, in your recommendation. Friends gather together, are then assigned to Committee, carry this to the County Societies, and then in June action will be taken by the State Society. That is our thought—to make compulsory the recognition of the family doctor. There is one place, here in the Minority Report, wherein we have epitomized this, but it does not seem probable that this Minority Group has completely solved all the problems. We left this an open question, and I feel this was good judgment on the part of the Minority Group.

Now, speaking of the Burlington County Hospital—and this is Morgan speaking—the people in a community sometimes get the wrong idea about a doctor who is not connected with a community hospital. They will say: "'A' is connected with the Burlington County Hospital but 'B' is not", and that brings up the question as to the advisability of having the community hospitals open or closed. That question remains for the local discussions. Morgan does not express himself, one way or the other, but merely calls this to your attention.

There are many other propositions which come up, in this connection, but the hour is late. There is one thing I want you to take home and think of. The State Society of Texas ordered copies of this final study and they are being distributed throughout the state, so that when their State Society meets there will be a uniform final decision. Your officers here have these Reports. In Pennsylvania, every County Society has been supplied by the State Society with a copy for 2 or 3 officers. This book is well worth an investment of $1.60 by a man who will take the time to study it. Thank you for your interest, and again thank you for your forbearance.

Dr. Conroy: I suggest that a rising vote of thanks be extended to the speakers of the evening.

Now, I would like to state to Dr. Curtis and Dr. Thorne that when I made the remark that the patient was beautifully taken care of, I did not mean to infer that I agreed with the Majority Report. I feel that the doctor is truly the "forgotten man" in that Report, and I feel, too, that the patient should come first, but we must also realize that we must make our living in this work, and we must consider ourselves also.

Dr. Goldstein brought up some of the questions mentioned by Dr. Morrison in his report and discussed them further.

Dr. Conroy: It seems to me that a great deal of the trouble in reference to the practice of medicine by nurses, etc., could be corrected by the doctors without outside help. If we had strength of character enough to prefer charges against nurses

or corporations who practice medicine illegally, it would be very effective.

I agree with Dr. Thorne that we should go on as we are, but I believe also that we should appoint an Economic Committee in our Society to study this question and report at a later meeting, after they have had an opportunity to go into this Report thoroughly, and I wish to appoint on that Committee Drs. E. R. Mulford, Emlen Stokes, Daniel F. Remer, R. I. Downs.

(Upon motion, the meeting adjourned.)

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The February meeting of the Camden County Medical Society was held in the Camden City Dispensary Building, February 7, at 9 p. m., with Dr. A. B. Davis presiding.

Prior to the meeting, the Business Committee met and heard a proposition from Dr. Fisher, Councilor of the Fourth District, in which this Society belongs. The Business Committee suggested that it would be well for this Society to act as host and entertain this group at its Spring meeting in conjunction with the April program of this Society.

The Treasurer reported to the Business Committee that there were only 12 delinquents and that most of those men could be counted upon to pay their dues within the next fortnight.

The minutes of the preceding meeting were read and approved.

Dr. William J. Browning, 134 North Centre Street, Merchantville, New Jersey, took the oath of membership and was welcomed to the Society.

The application for membership of Dr. William G. Shemeley, Jr., 7 Haddon Avenue, Camden, was read.

Dr. Alex. Macalister presented "resolutions" upon the death of Dr. William R. Powell, a member of this Society. Upon motion of Dr. Rogers, a copy of these resolutions was ordered sent to the members of Dr. Powell's family and a copy posted on the minutes of this Society. (See Obituary Section.)

Upon motion of Dr. E. B. Rogers, Chairman of the Business Committee, the Councilor District was invited to hold its Spring Meeting in conjunction with this Society at its April meeting. The details of this meeting to be conducted by the Councilor and the local Scientific Committee. This motion was seconded and passed.

Dr. D. F. Bentley, Jr., Chairman of the Educational Committee, announced the Annual Course of Post-Graduate Lectures given under the auspices of the State Medical Society and Rutgers University. The schedule of lectures should be in the hands of all members at this time. He reported that he had already received 2 acceptances from Gloucester County.

The Scientific Program consisted of Case Reports given as follows: "Syphilitic Pathologic Fracture of the Femur", R. S. Gamon, M.D.; "Excision of Elbow for Ankylosis". B. F. Buzby, M.D.; "Perparin a New Antispasmodic Remedy", H. I. Goldstein, M.D.; "Severe Limeburn of Both Eyes", W. G. Mengel, M.D.; "A Case of Osteomyelitis of the Jaw in a Nursling", V. Del Duca, M.D.; "Accidental Rupture of Ureter with Complications", D. F. Bentley, M.D.

These reports were discussed by Drs. D. F. Bentley, Jr., A. B. Davis, P. E. Shope, J. S. Shipman, A. H. Lippincott and H. I. Goldstein.

Communications were read by the Secretary from: Dr. John Marcy, acknowledging and thanking the Society for electing him to Honorary Membership; Dr. K. MacAlpine, acknowledging flowers; and the family of the late Dr. W. R. Powell, acknowledging expression of sympathy from this Society.

Dr. A. H. Lippincott was accorded the floor and spoke of the recent meeting of the State Welfare Committee in Trenton. He stated it was the desire of this Committee to have the Camden County Committee on Economics report its findings to the State Welfare Committee.

In response to the motion of Dr. William Shafer at the last meeting, the following members were appointed by the President to serve upon the Committee to Study the Report of the Committee on the Costs of Medical Care: Drs. T. K. Lewis, Chairman, George P. Meyer, David F. Bentley, Jr., A. L. Stone, W. J. Barrett, B. F. Buzby and H. F. Schrack.

Mr. W. Blankensteen, representing the Independence Indemnity Company, the Insurance Carrier of the State Group Health and Accident Policy, was accorded the floor and presented the policy offered to members of this Society.

There were 54 members present.

Dr. H. B. Diverty of Gloucester County was a guest at this meeting.

Motion for adjournment was made and passed unanimously.

ESSEX OOUNTY

Frank W. Pinneo, M.D., Secretary

The regular meeting of the Society was held Thursday evening, February 9, at the Academy of Medicine, Newark. The President, Dr. William H. Areson, called the meeting to order, and, after the reading of minutes by the Secretary, and their approval, introduced as guest-speaker, Hugh S. Cumming, M.D., Surgeon General of the U. S. Public Health Service, to talk on the "Relations Between the General Practitioner and the Public Health Official", a kind of topic always important, but increasingly so as "Preventive Medicine"—largely a function of the Government—extends its field and contacts with both the citizens and the physicians. The General delivered a well-prepared address, touching on the development of the Government's responsibilities in medicine, the advances in medical science, the widening vision of the public in "Preventive Medicine", and the interests of physicians in "Curative Medicine". His address was well received and greatly appreciated, as viewing the Government's responsibilities to the public broadly, but without prejudice, and with the aim of mutual understanding and coöperation for the good of all concerned. (Complete address to appear in a later Journal.)

In the business session, 33 new members were elected, of which group 14 were for Associate Membership, a new provision inaugurated last October, following action of the State Society which provided for it without State dues except to cover cost of the Journal, that has become very popular through enabling young practitioners, licensed within 2 years, to become allied with organized medicine and enjoy its privileges. Such membership expires by limitation in 2 years, when full "regular membership" will naturally follow.

Academy of Medicine of Northern New Jersey Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

The February meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held February 13 and was called to order by Chairman E. A. Curtis at 8.45 p. m.

Dr. Curtis appointed a committee, consisting of Dr. E. S. Sherman, Chairman; Dr. Lee W. Hughes, and Dr. E. Le Roy Wood, to nominate Officers for the coming year.

Dr. Edgar P. Cardwell described a patient who had been under his care for some time: Female, aged 27, suffering from intense pain in the ear which was relieved by breaking off the tip of an extremely long styloid process that could be palpated in the nasopharynx. Later the pain returned, and was relieved by an injection into Arnold's nerve through Shrapnell's membrane.

Dr. William J. Greenfield read a paper on "Studies in Laryngoneurology", saying in part as follows: The interpretation of many syndromes resulting from lesions of the cranial nerves is very confusing, and the writers on neuro-anatomy are still not in complete agreement concerning the paths taken by nerve impulses to and from certain parts of the head and neck supplied by the lower cranial nerves. In an effort to contribute something to our knowledge of this subject, 37 patients presenting motor or sensory disturbances of the upper respiratory passages were thoroughly examined for anesthesias, paralyses and other manifestations of lesions of the fifth, seventh, ninth, eleventh and twelfth nerves, and the results recorded for comparison and study. Several illustrative lantern slides were shown.

Dr. Henry B. Orton opened the discussion of Dr. Greenfield's paper, and presented a chart which he had prepared to illustrate the complex interrelations of some of the cranial nerves.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The stated Meeting of the Academy of Medicine of Northern New Jersey, held on February 16, 1933, was under the auspices of the Section on Surgery. Dr. Daniel Fiske Jones, F.A.C.S., Professor of Surgery at the Medical School of Harvard University, was the guest-speaker. Dr. Jones' sterling personality was an added attraction to a most interesting and enlightening discussion of "Treatment of Carcinoma of the Colon and Rectum". Dr. Jones spoke from a wealth of personal experience and was quite definite in his views.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular meeting of this Society was held at the Oakwood Country Club, February 16, with the following attendance: Drs. William and Charles Pedrick, Ralph Moore, Ralph K. Hollinshed, Don Weems, C. I. Ulmer, B. A. Livengood, Duncan Campbell, Harry Nelson, T. M. Galrdner, Oran A. Wood, William E. Crain, Horace M. Fooder, W. J. Burkett, A. B. Black, Dorothy Rogers, E. E. Downs, Fuller G. Sherman Edwin Ristine, J. Harris Underwood, H. L. Sinexon and H. B. Diverty.

Dr. Leon T. Ashcraft, Professor of Urology in the Hahnemann Medical College, and Chief of the Department of Urology of Hahnemann Hospital, gave an illustrated lecture on "Urology As It Interests the General Practitioner".

The committee investigating the costs of medical care reported it was making progress.

The society ordered official A. M. A. automobile emblems, on which will be inscribed the insignia of the Medical Society.

The physicians went on record as opposing Senate Bill No. 126, which would affect the State Medical Board funds.

The Educational Committee of the Gloucester-Camden County Medical Societies announced that the first of a series in a Post-Graduate Course for the members would be held March 1 at Camden, when Dr. John A. Kolmer, Professor of Medicine, Temple University, would speak on the Correlation of Newer Laboratory Tests to Clinical Medicine.

HUDSON COUNTY

Charles Sirken, M.D., Reporter

The regular meeting of the Hudson County Medical Society was called to order by Dr. L. A. Pyle on February 7, at 9.30 p. m., at the Carteret Club, Jersey City.

Dr. Barbarito stated: it is the opinion of the Committee on Constitution and By-Laws in reference to re-instatement of members, that an Active Member, dropped from the roll for non-payment of dues or by resignation, is eligible to re-instatement to his former status; in the former instance, on payment of dues, in the latter instance, on application only, but in either case, the admission assessment shall not be required.

It was regularly moved, seconded and adopted, that dues of $15 for the present year and $5 for the past year's dues, would re-instate to Active Membership a member who had defaulted.

Report of Membership Committee. In accordance with the desire to urge all physicians of Hudson County who are not members of the Society to join, a canvass of the 168 non-members resulted in 9 new applicants and a request by 35 men for application blanks. The canvass also revealed that there were between 105 and 110 physicians in the county who, for various reasons, have refused to join the County Society: and 44 members were delinquent for non-payment of dues to date. Harold C. Benjamin, M.D., Chairman.

Report of Welfare Committee. The following recommendations were unanimously adopted: That the Hudson County Medical Society protests against the plan of the Government of the United States in establishing Veteran Administration Hospitals, where adequate care is provided for by local institutions:

Further, disapproves of the practice of extending medical service, in any form and manner, *to veterans whose disability is not service connected;*

Also disapproves of the practice of the Government in extending medical care and surgical service to families of veterans.

We recommend for families of indigent veterans adequate medical and surgical care such as the facilities of local hospitals afford.

We advocate adoption of these recommendations, by the Hudson County Medical Society, and following their adoption, that they be submitted to the House of Delegates of the State Society for consideration.

In regard to the application made by Walter M. Bartlett, M.D., requesting the privilege of conducting a Free Clinic, the following resolution was unanimously adopted: "Inasmuch as the Hudson

County Medical Society has gone on record as disapproving the establishment of a Municipal Clinic in the town of North Bergen, on the ground that the existing Hospital clinic facilities were adequate, and in view of the fact that, in Jersey City and Bayonne, we believe that the existing hospital facilities are entirely adequate for the medical needs of indigent patients, we disapprove of this clinic on the grounds that it is unnecessary.

Relative to the petition submitted by the Dental Society, in reference to a plan concerning the operation of clinics, it was recommended that a joint meeting be called for the consideration of the scheme.

We recommend that the May Meeting be set aside for the discussion of matters that are to be proposed or acted upon by the House of Delegates of the State Society, and that the Scientific Section be omitted at this meeting.

That we support Dr. Quigley in his request that the Hudson County Delegates be instructed not to support Bill S-126, introduced by Mr. Reeves, which would not allow the State Board of Medical Examiners to use the funds collected from fines, and thereby prevent the prosecution of illegal practitioners.

It was regularly voted that all of the above resolutions in the report of the Welfare Committee be adopted.

It was regularly moved that the Report of the Maternal Welfare Committee be accepted, but that the recommendations relative to the Committee supervising the physical equipment of hospitals accepting obstetric patients; their obstetric records; their rules for consultation in abnormal obstetric cases; the control of circumcisions; all be rejected. The motion was duly seconded and carried.

The following named applicants were unanimously elected Associate Members of the Society: Harry Fialk, M.D., Union City; Nathan Frank, M.D., Jersey City.

The subject for consideration at the Scientific Session was: "A Symposium on the Treatment of Certain Phases of Heart Disease."

Dr. John M. Cassidy spoke on: "Treatment of Congestive Heart Failure with Digitalis." He said, in part: "I follow the functional classification of the New York Heart Association. Class (1) All cardiac patients with organic heart disease, showing no signs or symptoms of heart failure and who are able to carry on their ordinary physical activities. Class (2-A) Patients in whom ordinary physical activity causes symptoms of distress, but who do not, as the usual thing, have any signs or symptoms of either the anginoid or congestive type of heart failure; and, (B) patients in whom less than ordinary physical activity causes symptoms of distress, and who usually show some signs or symptoms of either type of heart failure. Class (3) Patients who have signs or symptoms of heart failure at rest."

Treatment of Class 3 patient: He is put to bed, digitalis medication is started and a graphic chart is kept, showing the daily amount of digitalis taken, weight, the pulse deficit, the fluid intake and output. Digitalis should be used in all cases of congestive heart failure irrespective of the rhythm. The most spectacular results take place in those patients who have an abnormal rhythm, such as auricular fibrillation or flutter. The form of digitalis used makes no difference so long as it is a potent preparation. My own preference is for a tablet of 1 gr. of the whole leaf. With a standardized dropper, a liquid preparation can now be used. I follow the method suggested by Dr. John Wyckoff, namely, 9 gr. in the first 24 hours and 6 gr. daily until the patient is completely digitalized. Complete digitalization has resulted when the patient has become nauseated or vomits; when he complains of yellow vision; when the pulse deficit is wiped out; or when a toxic rhythm develops. If clinical improvement comes before the point of intoxication, digitalis does not have to be pushed to that extent. After this, the patient is kept on a maintenance dose of about 3 gr. a day. Restriction of fluids, with the intake kept below the output, will also aid in elimination of edema.

The Class 2-A patient reduces the amount of physical activity, and digitalis may or may not be used. For the Class 2-B patient, rest, digitalis, and restricted fluids are indicated. Since they are ambulatory, and I see them about once a week, I calculate the amount of digitalis necessary for complete digitalization, and the amount necessary divided by 7, gives the daily dosage.

Dr. Thomas White spoke on the "Treatment of Congestive Heart Failure by Means other than Digitalis", as follows: In addition to rest and proper digitalization, the question of diet is important. At the beginning of treatment, if edema is present, a special diet is helpful. Frequent small feedings of a dry diet is best tolerated, and only a small portion of salt is to be used in cooking. It is wrong to restrict meat, eggs or other proteins to these patients. Their body protein is breaking down and, in addition, those with long-standing hypertension frequently have been living on a low protein intake. Restrict protein only where there is a high degree of renal insufficiency. A liberal carbohydrate intake is suggested as a means of supplying an abundance of glucose to the weakened myocardium, as well as to guard against acidosis if the patient has been vomiting.

When diuretics are resorted to, restrict fluid intake to 1200 c.c. daily, and measure the urinary output daily if patient cannot be weighed frequently. Of the mercurial diuretics, salyrgan is preferred, and is to be given intravenously 0.5 c.c. at first, increasing to 1 or 2 c.c. if necessary; it can be given 2 or 3 times weekly, and is contra-indicated in acute nephritis or marked renal insufficiency. Of the xanthines, theophylline (theocin) is the most efficacious, but is apt to produce nausea and vomiting. It is given in 5 gr. doses 3 times daily for 3 to 6 days. Theobromine and theobromine-sodium-salicylate, are not so apt to produce gastric symptoms, and may be given 40 to 60 gr. daily for 4 to 6 days, stopped 1 week, and resumed. Ammonium chloride, ammonium nitrate and calcium chloride are sometimes useful. Doses of 100 to 150 gr. daily are required. After 3 to 6 days they are likely to cause distress.

Sedatives are valuable adjuvants. During critical stage of congestive failure, morphine ¼ gr. to be used at night for first few days. Subsequently, phenobarbital 1½ gr. once or twice during the night. With much edema of extremities, incision and drainage are of real value and should be employed. For the acute sudden type of failure, with venous engorgement and pulmonary edema, phlebotomy of 300 to 500 c.c. may be a life-saving measure, used together with morphine and atropine.

Dr. H. Von Deesten spoke on "Treatment of the Nervous Cardiac". Patients with organic heart disease may have symptoms referable to the nervous system, and, on the other hand, nervous patients may have also organic heart disease. The laity fears heart disease and high blood pressure second only to cancer. The propaganda against cancer, and the discovery of the sphygmomanometer, are not unmixed blessings, since both engender fear, and fear induces morbidity. Dr. Fran-

cis Peabody in his book entitled "Care of the Patient" says: "You will find physicians, by wrong diagnosis and ill-considered statements, are responsible for many a wrecked life, and you will discover that it is much easier to make a wrong diagnosis than it is to unmake it." When to keep silent and when to give a frank reassuring explanation of certain findings in the course of a physical examination, is an art, probably learned only in the school of experience. Some physicians do not care to treat these nervous patients, and it is a mistake for them to say—"You are only nervous"—"nothing wrong with your heart"— and give a prescription of bromide. If the physician recognizes the psychic factor as the etiologic basis, patience, time, sympathy, tact, judgment, explanation and reassurance, are his main therapeutic agents.

If the psychic factor is definitely related to an injudicious remark, and you have gained your patient's confidence, the problem may be simple. The same is true of tobacco and coffee. Much more difficult is the problem when the factor is due to prolonged anxiety, irregularity of the heart subsequent to a severe illness, worry over sudden deaths, or a defense neurosis due to sexual or domestic incompatibility. The words of Dr. S. J. Meltzer should stand in good stead: "Lighter than air is psychotherapy. Do not practice it consciously. You are training yourself to be a humbug. Have such a thorough knowledge of your subject as entitles you to speak with conviction; be sincere in dealings with your patient, so as to gain his confidence; have sincere sympathy—which ought to manifest itself with obvious demonstration; be practical in your advice and talk to the patient in common-sense terms, and you will have practiced psychotherapy honestly and successfully."

When I think the patient has a psychic factor, I read to him the following form. "We realize now that many sicknesses are made worse by worry, and fear, and too much thinking, and I must ask you to tell me whether you have any mental or emotional distress from any cause. I will read you a list and ask you to say *yes* or *no* to each. You need not give any details unless you wish:

Financial strain.
Business problems.
Legal complications.
Social difficulties.
Domestic or sexual difficulties.
Religious.
Fear of the future events or acts.
Fear of disease, physical or mental.
Any undecided problem or conflict.
Past shocking experience.
Past grief or disappointment.
Unspecified.

Endeavor to make them understand that you believe their symptoms are real. Don't use the word imaginary; it will preclude your usefulness for all times. It may be a disease of the imagination, as has been aptly said, but the symptoms are real, not imaginary. Explain that palpitation and polyuria occur in normal people. Insist on exercise. Write out a daily routine with specified times for exercise, rest, massage, hydrotherapy, reading, etc. Sedatives are indicated, but discontinued with improvement. One must emphasize the importance of emotional data in the medical history of a patient with cardiac symptoms.

Dr. A. E. Jaffin spoke on "Treatment of the Anginoid Syndrome", as follows:

Pseudo-Angina

(1) *Mesaortitis, or luetic disease of the aorta.* Without evidence of myocardial insufficiency, treatment should be antiluetic. Don't give arsenicals, at first. Begin with bismuth, twice weekly for at least 2 weeks, and then continued weekly for a total of 12 to 16 injections. In third week, may begin with not more than 0.05 c.c. neosalvarsan and continued weekly with slightly increasing doses (0.1-0.15-0.3) until patient has received 15 injections of neosalvarsan, or a total of 4 gm. This, if well tolerated, could be given twice the first year and once the second. The iodides should, preferably, supplement the periods of injections.

(2) *The gastro-cardiac syndrome.* Here we have an elderly individual with high diaphragm, pushing apex beat well out beyond the normal; a ringing quality to the second aortic; a physiologic blood pressure of 150. On a full stomach, he may complain of pains, palpitation and extrasystoles. The diagnosis of angina may be hard to over-ride but with restriction of diet, logical management of constipation, and diaphragmatic breathing, one may climinate the anginal pain and establish the diagnosis.

(3) *Heart neuroses.* Real pains are rarely at the apex. In the neurotic, the pain is indicated with a finger at the apex; in a *real angina* the patient places his whole hand over the precordium.

(4) *Pleural adhesions.* If left-sided, may pain in bad weather. Simple anodynes and counter-irritation will suffice.

True Angina

(1) Coronary angina, as encountered in coronary sclerosis with occlusion. In families with anginal tendencies, make periodic health examinations, including blood sugar estimations. One with an elevated blood sugar is more apt to develop coronary sclerosis. Correct errors of diet, high pressure physical or mental methods, dissipation, over-strenuous athletic activities, over-weight, lack of sleep, and moderation or prohibition of sexual indulgence. Remove definite foci of infection and study reaction to tobacco.

Excessive fluid intake is an exciting factor in angina. Moderate use of alcohol may be very wholesome. Moderation with salt, tea and coffee is allowable. Constipation of very old people may be relieved with rectal lubricants. Nauheim baths are excellent.

(2) Angina pectoris (Heberdon's type). Avoid exertion, excitement, exposure to cold winds, contact with cold sheets, coitus, or gastric distention. At time of attack, patient, with a tube of nitroglycerine tablets in pocket, puts one under the tongue. If no relief, inhalations of amyl nitrate may be more effective. When there are more frequent or prolonged attacks, drugs with longer-lasting effects, such as sodium nitrate or erythrol-tetra-nitrate, are better. An expensive English drug, manitol-hexa-nitrate, is somewhat better tolerated by the stomach. Sodium nitrate gives full effect in 5 minutes and lasts 1 to 2 hours. Erythrol-tetra-nitrate takes 15 to 20 minutes but lasts 3 to 4 hours. If morphine is necessary, one should suspect an occlusion rather than angina. Euphylline or other theobromine preparations are very beneficial: theobromine sodium salicylate, 7½ gr.; phenobarbital, ⅓ gr.: papaverine hydrochloride, ⅔ gr.; quinine muriate, 1½ gr.; taken 3 times daily for 3 weeks. This will enable a man to walk up a slight grade and do other things which he would otherwise be unable to do. Another measure that is useful in preventing attacks, is the taking of a nitroglycerine tablet before exposure to cold air,

upon leaving the theatre, or in anticipation of excitement. Diathermia and ultra-violet rays to the precordium are beneficial. In an exceptional case, one may have to resort to nerve blocking. Section of the nerves is to be condemned. A hot toddy at night, or at beginning of attack, may have same desirable effects as nitroglycerine without its unpleasantness.

(3) *Coronary occlusion.* With a positive diagnosis give ½ gr. morphine at once, and do not hesitate to repeat if necessary. Oxygen, in proper tents, with 50% concentration, is equally efficient. After morphine, apply heat to body and extremities and make patient quiet and comfortable. If circulation is critical, give caffeine sodium benzoate intramuscularly. In less urgent case, give intravenous injections of metaphyllin. Another valuable remedy is glucose in 50% solution, 25 c.c. injected daily for first 2 or 3 days only. Vomiting is a bad sign, and here, stimulation and the glucose injections are especially indicated. If tolerated, liqueurs and champagne in ounce quantities every hour or so served with ice. With signs of dehydration give 5% glucose subcutaneously. Quinidine in small doses may prevent the frequently fatal ventricular fibrillation. A practical recent suggestion is the administration of 10 gr. of theobromine sodium salicylate with 3 gr. of quinidine every 8 hours. This protects against a very large danger and only introduces a very small one in the very occasional case of quinidine idiosyncrasy. After the tenth day, quinidine may be omitted and theobromine sodium salicylate continued. During first 2 or 3 emergency days, fresh citrous fruits are advocated. Keep patient in bed always, at complete rest for at least 6 weeks. First give massage during this period and later gentle passive movements. This gives greater safety in beginning graduated exercise after leaving bed. Occasional heart block treated with small repeated doses of adrenalin.

Special Meeting

Held February 3, 1933

Dr. Louis Pyle presided on the evening of February 3, at one of the largest attended meetings in the history of the Hudson County Society. He explained that this meeting was called as a result of the recommendation of a Special, and an enlarged, Meeting of the Executive Committee, at which there was discussed the advisability of replying to a *letter* issued by Mayor Frank Hague through the public press; which letter was published in response to *a write-up* by the press itself as to certain matters discussed at a meeting of the Jersey City Medical Society. An *abstract* of the article relative to the discussion at the meeting of the Jersey City Medical Society, as printed in the local press, and the reply thereto by Mayor Frank Hague, follow:

Abstract of News-paper Report of Jersey City Medical Society Discussion

"Four courses of action to determine the cost of medical care to the people of Jersey City at the Jersey City Medical Center were recommended by the Board of Economics of the Jersey City Medical Society.

(1) Legal action, costing between $15,000 and $20,000, in an attempt to expose alleged high costs of medical care resulting from flagrant and unnecessary extravagance at the Jersey City Medical Center.

(2) Educating the public through propaganda on medical costs commensurate with medical care.

(3) By a coöperative program with the city administration.

(4) Close the books, put out the lights, and go to sleep."

The Mayor's reply, on January 27, 1933, follows:

Doctors Get Hague Reply

"This story is not news to me because these tirades against the Medical Center have been going on at meetings of this Society.

Now that the depression is at its height and the dollar is scarce, these doctors, who have formed themselves into the *Jersey City Medical Society* and who have largely relegated to the rear the outstanding high class practitioner in Jersey City, have again brought the subject into open discussion and given it to the press. They are being driven frantic because they are not permitted to have the last say on these unfortunate people who seek relief at the Medical Center because of their inability to pay for the services of a physician; and because they have been denied the privilege of associating themselves with this institution.

The percentage of the membership, who I do not believe have the sympathy of the highminded physicians who have frequently resented such attacks, brought up for discussion the question of cooperating with the city authorities. The city authorities want no coöperation from an element of this kind nor do we want them to have access to the Medical Center because they have no interest in our sick who cannot afford to pay fat fees.

This is the burning question between this group and the authorities. They refer to an investigation. I have never been approached or interviewed regarding an investigation; neither has Dr. George O'Hanlon, the Medical Director. The only information that I have ever received has been complaints, from time to time, coming from this element—that I am depriving them of a livelihood by giving medical care and attention to the sick of our city and they do not propose to stand for it.

I want to say to this element, and any other element that wishes to take on an issue of this kind, that as long as I am Mayor of this city this institution is going to remain the efficient one that it has established itself to be and *I will not permit the Medical Society or any other society to attempt to dictate its policy.* The management of the Medical Center is in most competent hands in the person of Dr. George O'Hanlon and his able assistants. This society does not want public hospitals in Jersey City. *All they want is private institutions where they can have at their mercy these unfortunate sick.*

I am proud that I am able to stand between an element of so-called professional men such as this group sets itself up to be and the people of our city. If they want fight I am ready and I promise them now that I will not come out the loser, and it is possible that some of these aggressive members may be silenced when I get through with them.

I have no hesitancy in going before the people of Jersey City and giving an accounting of the management of this institution and I have no fear of defending it against attacks by a group such as this whose motives are not pure and who are not for the best interests of the institution or the people for whom it was provided. But on the contrary, they are for the almighty dollar. It is probably discouraging for them to stand and see thousands of our unfortunate people being cared for at the Center; but is most encouraging to me to be present and see these people who are unable to

pay, being given every attention and to witness the wonderful cures that have been effected.

I did not start this controversy and I am not looking for trouble, but there will be trouble if this Society asks for it and I promise them that I will not run away from it. My management of this institution is an open book and as to its efficiency and the manner in which its affairs are conducted this question was investigated by experts engaged by the Case Committee a few years ago and after a thorough investigation had been completed I requested that these experts make known their findings but they refused to do so. That in itself demonstrated the degree of efficiency which surrounded it.

It is very interesting to note that their criticism was also directed at the ambulance service rendered by the institution. The records for the past 2 or 3 years will show close to 40,000 calls and they can single out but 2 cases with an alleged cause for complaint, and for those 2 cases feel that the night calls by ambulances should be discontinued. This will indicate their interest in the welfare of the poor people of the city who have no place to seek relief but should be left to suffer and even die because of lack of medical care and attention. The ambulance service shall continue the same as it has in the past.

I am strongly of the opinion, however, that the criticism of the management of this institution and the good work that it is doing is not subscribed to by all of the physicians of Jersey City."

The Executive Committee recommended to the Society that the Mayor's letter in the press be answered in the public press, in just one statement, and that we do not enter into any further controversy thereafter. Dr. Pyle said that it was up to the Society to accept or reject the Executive Committee's recommendation, and if it accepted, then they were offered the choice of 1 or 2 statements for the public press that had been prepared in order to save time. These statements were the result of a tremendous amount of deliberation and in their final forms had had the advice of the State Society Counsel.

Drs. Londrigan, Rector, Butler, M. Shapiro, Norton took the view that the whole matter was not up to the Hudson County Medical Society to decide upon, but rather a question for the Jersey City Medical Society. Dr. Shapiro made the motion that "In view of the fact that this is not a controversy started by the County Medical Society, and in view of the fact that the different municipalities are not interested in this matter, I move this meeting be adjourned." A standing vote on this motion was 72 for adjournment and 75 against adjournment.

The 2 statements in reply were then read by Dr. Barbarito, and considerable discussion followed, in which the members were asked to weigh both sides of the question thoroughly.

Dr. Charles Kelley said that he had very good reason to believe that the administration at the hospital was reading to give the doctors a sympathetic ear if approached. Along these lines, he said, a small, unofficial group, consisting of Drs. Quigley, Pyle, Pollak and himself, took it upon themselves to call on Dr. O'Hanlon a few days ago, and that as a result of that conference it was agreed that the following plan be submitted to the Hudson County Medical Society at this special meeting tonight:

That a committee should be appointed, by the Chair, to have whatever conferences necessary to ascertain and formulate the objectives sought by the Society at the Medical Center, and that conference or conferences be had with the Hospital authorities and that committee, seeking coöperation and satisfactory adjustment of problems, as they had assurances that such a committee would be favorably received by Dr. O'Hanlon.

Dr. Kelley stated that that last statement was absolutely authentic.

Arguments *against* an answer were also made by Drs. Pollak, Perlberg, Spence, Quigley and Koppel.

In favor of an answer, talks were made by Drs. Barbarito, Swiney, Reitnauer and Maras.

A closed ballot was held as to whether (1) to answer or not to answer the public press, and (2) which answer to make.

The official ballot was announced as: 82—"Yes"; 92—"No". (Not to answer.)

Meeting adjourned at 2.30 a. m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The Mercer County Medical Society met in the Nurses' Lecture Room of the Mercer Hospital, on February 8, at 8.30 p. m., with President Proctor in the chair.

The President suspended the usual order of business, and introduced Dr. Temple Fay, speaker for the evening, who delivered an exceptional lecture on the subject of "Critical States of Stupor, Coma and Convulsions, and Their Management in General Practice".

Dr. Fay, with his expressive elocution, held the attention of his large audience throughout the delivery of a lecture, embracing etiology, physiology, symptomatology and pathology of these conditions, with precise elucidation, and with particular emphasis upon a perfect understanding of the principles of hydraulics in relation to the treatment. In facetiously advocating a "course in plumbing" in our Medical Schools, Dr. Fay clearly defined the significant features of hydraulics—i. e., non-compressibility of liquids, "a pint's a pound", etc., in relation to cerebral and spinal pressure.

Many interesting slides were shown, demonstrating the theories applicable to results following operation, advanced by Dr. Fay along with other research workers.

MIDDLESEX COUNTY

Medical Section of Rutgers Club

J. H. Rowland, M.D., Secretary

NOVEMBER MEETING

The regular meeting of the Medical Section of the Rutgers Club was held at the Alumni House, Queens Campus, Rutgers University, on November 25, at 9 p. m., with 22 members present and Dr. Gutmann presiding. There being no special business to transact, the speaker of the evening, Dr. R. F. Carter, Associate Professor of Surgery, Columbia University and the Post-Graduate Medical School and Hospital, was immediately introduced, to present a paper entitled "Differential Diagnosis and Treatment of Lesions of the Stomach and Duodenum". Dr. Carter gave also a brief summary of his recent studies of the gall-bladder; both subjects being illustrated by drawings and specimens.

Dr. Carter stressed the significance of certain signs and symptoms; the advantage of an exhaustive examination before deciding on diagnosis; the use of x-rays, and of duodenal drainage; and the many advances and disappointments in treatment. His presentation was complete and instructive.

The medical aspects of the subject were discussed by Dr. Gutmann; the surgical aspects, by Dr. Hoffman; the radiologic by Dr. William Klein; and the pathologic by Dr. Molton. The whole evening was thus made valuable and interesting.

At a late hour the members were entertained with refreshments supplied by the Entertainment Committee: Drs. Brody, Walker, Applegate and Saulsberry.

December Meeting

The regular monthly meeting of the Medical Section of Rutgers Club was held at 9 p. m. on December 16, at the Alumni House, Queens Campus, Rutgers University. There were 22 members present. In the absence of the Chairman, Vice-Chairman Howley presided.

There being no business to transact, the speaker of the evening was immediately introduced. Dr. Roger H. Dennett, Professor of Pediatrics at Columbia University and Director of Pediatrics at Post-Graduate Hospital, New York City, spoke on "Current Pediatric Topics".

Considering the season, he spoke first on infections of the upper respiratory tract, stressing the point of susceptibility. He spoke at length on prevention, mentioning contacts, with relation to adults especially, over-dressing, too much heat, radical changes in body temperature due to over-heating, and exposure. He mentioned tonsils and adenoids, from the standpoint of prevention. Food, especially with high fat and carbohydrate, is a predisposing factor. Dr. Dennett spoke of the use of vaccine as a helpful measure in about 50% of the cases, and stressed the advisability of using fresh vaccine, i.e. vaccines made of the prevalent germs causing infection.

From the standpoint of differential diagnosis, he mentioned mild infections of the tonsils and pharynx, stressing particularly sub-acute tonsillitis, which is readily relieved by salicylate and hot compresses.

Considering the removal of tonsils, he said that while they may be removed in particular patients as early as 1 year of age, the opportune time for removal is 5-6 years, indications being size, noting external or submerged tonsils, cardiac complications, chorea, rheumatism, pyuria, malnutrition, convulsions, epilepsy, and tender glands in the neck.

Dr. Dennett mentioned otitis as a complication in upper respiratory tract infections, and emphasized the point that incision of the ear-drum is not always associated with fall in temperature, due to inflammatory conditions in the area proximal to the middle ear. He pointed out the necessity for wide experience, sound judgment in the opening of ear-drums, and the use of dry and wet dressings after incision. He spoke of the diagnosis of mastoiditis, and indication for operation, stressing that fever and discharge are not sufficient signs, inferring that discharge would continue so long as there was any inflammation of the respiratory tract. The cardinal points for operation are pain, increasing deafness, sagging of the posterior wall, and narrowing of the canal.

The paper was discussed by Drs. Johnson, Toy, Brown, Howley and Sullivan.

After the discussion the members were entertained by Drs. Rowland, F. L. Brown, Fagan and Faulkingham.

January Meeting

The regular monthly meeting of the Medical Section of the Rutgers Club was held at the Alumni House, Queens Campus, Rutgers University, on Friday, January 17, at 9 p. m.

The speaker of the evening, Dr. H. O. Mosenthal, Professor of Medicine at Columbia University and Director of Medicine at the New York Post-Graduate Hospital, whose subject was to have been "Hypertension and Nephritis", was unable to be present, much to the regret of the members and guests.

At about 10 p. m. the members discussed various phases of hypertension and nephritis, with much benefit to all. The discussion was opened by Drs. Brown and Gutmann.

At a late hour the members enjoyed refreshments provided by the Entertainment Committee, who were: Drs. Feher, Forney, Gutmann and Cronk.

The gathering adjourned spontaneously.

MONMOUTH COUNTY

R. A. MacKenzie, M.D., Reporter

December Meeting

The Annual Meeting and election of officers of the Monmouth County Medical Society was held on December 14, at the Squankum Inn near Farmingdale. About 40 members gathered to enjoy an excellent dinner. Subsequently, the Nominating Committee made its report and election results were as follows:

Dr. Robert E. Watkins, President; Dr. John Maher, Vice-President; Dr. Walter Gosling, of Red Bank, Treasurer (reëlected); Dr. Daniel Featherston, Asbury Park, Secretary (reëlected); Dr. Robert A. MacKenzie, Asbury Park, was named Reporter.

Members of the Executive Committee will include Drs. Stanley Nichols (the retiring President), Watkins, Maher, Warren, Fairbanks of Freehold, C. Byron Blaisdell of Long Branch, Frank Altschul of Long Branch, and O. K. Parry, Asbury Park.

Following the election Dr. Stanley Nichols discussed the report of the "Committee on Costs of Medical Care". He deplored the Majority Report and pointed out definite objections to the schemes which they proposed, expressing the view that socialization of medicine would lead to a lowering of the quality of medical service to the public. Dr. Nichols endorsed the Minority Report and urged the Society to assume the responsibility of leadership in solving the problems presented by the need of adequate health service for all.

In the County of Monmouth the medical profession coöperates closely with the various public health agencies and it is not too much to hope that some of the plans now being worked out here may serve as examples to be tried on a larger scale.

Perhaps the most significant development in the County Society activities during the past 12 months has been the functioning of the Executive Committee, composed of 5 members in addition to the President and the Secretary. This committee meets once a month at an hour and place separate from that of the regular Society meeting and disposes of routine business, formulates policies, and so forth. By reason of its activity, this Committee has found it possible to shorten the business session of the regular monthly meeting a great deal

and make the scientific program, as it should be, of first importance at these meetings. There has been a large and appreciative attendance at all the meetings.

January Meeting

The regular monthly meeting of this Society was held at the Fitkin Morgan Memorial Hospital on Wednesday evening, January 25. President Robert E. Watkins, of Belmar, opened the meeting. Most significant among the matters of business was the discussion of the recently publicized charges of the Casualty Underwriters Association, of Newark, to the effect that ambulance chasing by members of the legal profession, and unethical practice in the care of accident cases by physicians, were prevalent in Monmouth County. By unanimous vote of the Society, the Secretary, Dr. D. F. Featherston, was authorized to address a letter to President Walter Schaefer, of the Casualty Underwriters Association, of Newark, New Jersey, expressing the interest of the County Medical Society in the statements attributed to his office and offering coöperation in any investigation which may be conducted, the Monmouth County Medical Society sincerely desiring to end any abuses, if such exist, of the Compensation Laws. It is interesting to note that following publication in the local papers, of this stand by the organized medical profession, the County Bar Association, the President of which had disclaimed any knowledge of ambulance chasing tactics on the part of members, also went on record as to willingness to assist in any investigation of such practices.

Dr. Charles Graves, a member of the Staff of the New Jersey State Hospital, at Marlboro, New Jersey, was elected to membership, and the name of Dr. William Shanik of Asbury Park was presented for consideration.

The Scientific Program, devoted to "urologic subjects", was arranged by Dr. C. Byron Blaisdell, of Long Branch. Dr. Blaisdell introduced Dr. David M. P. Magee, of Asbury Park, who presented a paper entitled "Present Status of Trans-Urethral Bladder-Neck Resection". Dr. O. S. Lowsley, of New York, then presented a paper on "Prostatectomy and Indications for Bladder-Neck Resection". Both papers were full of interest and a very profitable discussion followed their presentation.

Personal Items

Dr. James F. Ackerman, of Asbury Park, Dean of the practicing physicians along the Atlantic Coast, and an Ex-President of the Monmouth County Medical Society, is convalescing from 3 months of illness. He is now able to be downstairs, sees many friends and directs much of the business of the Fitkin Memorial Hospital from his home. Dr. Ackerman is President of the Board of Trustees of the Fitkin Morgan Memorial Hospital.

Dr. Raoul Pietri, Neurologic Surgeon, of Asbury Park and Long Branch, has returned from a month's vacation in Havana.

Dr. James A. Fisher sailed on February 9 with his son for an 18-day cruise in the Caribbean.

Dr. C. A. Pons and Dr. S. C. de Pons have been victims of influenza.

Dr. R. E. Watkins, President of the Monmouth County Medical Society, has completely recovered from an operation performed late in November for removal of a semilunar cartilage in his right knee. This operation was performed by Dr. Barclay Moffat, of Red Bank, at the Fitkin Hospital.

Dr. William K. Campbell, of Long Branch, a recent President of the Monmouth County Medical Society, has given much time and effort as Chairman of a Depositors Committee working toward the re-opening of the Citizens National Bank of Long Branch, in which city he practices his ear, eye, nose, and throat specialty.

Testimonial Dinner to Dr. Harry Slocum

On Saturday evening of January 28, an event of much interest took place at the Norwood Country Club, in West Long Branch. A Testimonial Dinner was given to Dr. Harry B. Slocum, Senior Surgeon and Chief of Staff of the Monmouth Memorial Hospital, by members of the Staff. The occasion was in honor of the completion of 10 years' service by Dr. Slocum as Chief of Staff.

The speech of presentation was made by Dr. William K. Campbell, of Long Branch. O. N. Auer, Superintendent of the hospital, spoke on behalf of the institution in praise of Dr. Slocum's efficient and faithful service. Dr. John E. Maher, of Long Branch, spoke for the surgical service; Dr. Frank J. Altschul, of Long Branch, represented the medical division; and Dr. William G. Herrman, of Asbury Park, appeared for the specialists. The speakers were introduced by Dr. Daniel F. Featherston, of Asbury Park.

During the course of the evening, telegrams of congratulation were read from the various members of the Board of Governors, Nurses' Alumni, and intimate friends of Dr. Slocum.

In reply to the speech of presentation, Dr. Slocum was quite overcome by emotion. He spoke of the great change which has taken place in the hospital during the 10 years from the point of view of the services and equipment. He urged the members of the Staff to make full use of the complete equipment and up-to-date services of the hospital in an effort to increase their skill and to render more efficient service in the treatment of the sick.

"Financially", said Dr. Slocum, "the present months are trying ones for the hospital and the medical profession. The hospital wards are full, but the private rooms, to which we look for the maintenance of the hospital, are not in demand. It has been necessary, therefore, to run the hospital as economically as possible and to look to the patients for all the revenue we can. However, we have never turned away a sick person; we have never refused treatment to anyone, and I am sure we are rendering as good hospital service as can be found anywhere in the East."

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the Morris County Medical Society was held the evening of February 16 at the New Jersey State Hospital, Greystone Park, with President Pinckney presiding over an attendance of upward of 50 members and guests.

The feature of the evening was presented by Dr. Douglas Quick, of the Memorial Hospital, New York City; the title of his paper being "Radiation in Cancer". The paper was designed to permit a more general discussion on indications for use of radium and x-ray radiation and the head and neck group cases, with combined treatment by x-rays, radium and surgery, stressed.

The speaker pointed out that during the past few years radiation has come to be used as of value in cancer therapy; that the accumulated experiences with radium and x-rays give us today a considerable amount of rather accurate information on which to base the usage of these agents; that at least the empiricism of 10 or 15 years ago has been replaced by methods of reasonable accuracy founded on the observation and experiences of many workers, although such detailed information has not been widely disseminated; that the average physician, especially in general practice, sees relatively

few cases of cancer a year and consequently there is a certain degree of misunderstanding as to the place of radiation (radium and x-rays) in the cancer field; that, through the influences of physical agents, the curability rate is gradually being increased and the severity of operative procedures with resultant shock and mortality is being gradually lessened and the extremely mutilating operative procedures are decreasing and there is no longer the necessity for performing eleventh hour operations on advanced cases for the sake of "doing something"; that he did not mean to imply that operative surgery is being superseded by the use of physical agents and the treatment of cancer is largely a surgical problem; that the actual amount of operative surgery is probably about the same but the severity of the procedures is decidedly reduced and the ultimate results improved; that through the coördination of modern irradiation therapy and surgery a new type of "cancer surgery" is being well established; that the 2 agents or methods are strictly complementary and not competitive and that progress is to be made through a closer coördination rather than on a competitive basis; that there are few cases of cancer in which the agents of surgery, radium and x-rays do not play a part to advantage at some stage of the case. (The paper is being submitted for publication.)

By means of lantern slides, Dr. Quick showed and explained a very interesting list of patients exhibiting the condition, explaining the technic of treatment and the results.

Dr. Quick presented and portrayed his subject both interestingly and instructively and answered all questions presented in the discussion, which was entered into by Drs. Christian, Young, Haven, Lathrope, Rice, Larson and Pinckney.

Other matters of interest to the Society were introduced by President Pinckney. Dr. E. S. Sherman being called upon as Chairman of a Committee of the State Medical Society that met with the Morristown Emergency Relief Committee, explained the outline of a plan for medical care for indigent persons, which at least recognizes the value of the physician and fixing a fee of $2.50 for house calls and $1.50 for office calls, to be paid by the Emergency Relief Committee to physicians who register their willingness to coöperate in the plan; explaining also the coöperation of the physicians in the matter of selection of food and in the writing of prescriptions so that their filling will not cost 2 or 3 times more than necessary; this to be accomplished by prescribing medicines by their own names and not by trade names. A letter is to be sent to each member explaining the plan and outlining the procedure for coöperation.

Dr. Larson, being called upon, spoke on the matter of certification by the State Society of local specialists, under the present plan, and suggested that members be prepared to enter into a thorough discussion and consideration at the March meeting.

After adjournment refreshments and a social period were enjoyed in the cafeteria.

PASSAIC COUNTY

Wayne W. Hall, M.D., Secretary

The regular meeting of the Passaic County Medical Society was held at the Health Center, Paterson, on Thursday, February 9, at 9 p. m., with an attendance of 72.

Dr. Carl Eggers, Attending Surgeon, Lenox Hill Hospital, New York, presented a most interesting and instructive paper on the "Treatment of Empyema".

Dr. Eggers emphasized the differentiation of various types of pleural effusion, the various causes of the prolonged febrile course, adequate drainage of all cavities, and proper convalescent care.

The paper was discussed by Drs. Andrew F. McBride, L. Shapiro, William Spickers, and J. Rocmer.

Dr. McBride made a report on the work of the State Society's Welfare Committee, opposing S. 126, which would deprive the State Board of Medical Examiners of funds which have heretofore been used for prosecuting illegal practitioners, and for other work carried on in the interest of the Medical Profession. He also informed us of the first meeting of the Sub-Committee on the Costs of Medical Care, of which he is Chairman.

SOMERSET COUNTY

Alfred M. Sferra, M.D., Secretary

The regular meeting of the Somerset County Medical Society was held in the Nurses' Home on February 9, with President Flynn in the chair and the following named members present: Drs. Barbour, Ely, Field, Flint, Flynn, Hegeman, Lawton, Levy, McConoughy, Pogoloff, Renner, Smalley, Stillwell and Sferra.

It was decided to have our guest speaker, Dr. Morton S. Brody, of New Brunswick, deliver his paper on "A New Method for the Treatment of Vesical Neck Obstructions". It proved a worthwhile subject, as it covered an old field in a new style, and was illustrated by numerous lantern slides. Dr. Brody was given a vote of thanks for his efforts.

The Secretary read the "resolutions" on the death of Dr. George Lewis Mack, together with a short account of his life.

The Society was informed, by a letter from Dr. Henry O. Reik, the Executive Secretary and Editor of the Journal, that the President of the County Society shall act in conjunction with the Red Cross, as "leader or local director of all medical affairs, in case of any disaster that might befall in our county."

A letter from Dr. James J. McGuire, Secretary of the Board of Medical Examiners, was read, requesting that the Society support the Board in its stand, as the State Medical Society is doing, in opposing consolidation of the professional boards and any change in the Budget Law that would take away the "dedicated funds" of the Board. After some discussion it was moved and seconded that the Secretary should write Senator Kuser, of Somerset County, informing him that our County Society supports the State Society and Board of Medical Examiners in these matters.

A letter from President Lippincott, relative to the "Report of the Committee on the Costs of Medical Care", was read, where-in he suggested the appointment of a committee from our County Society to study these reports.

Discussion followed, and it was pointed out that the *Economic Number* of the State Journal carried a comprehensive account of this report and that no special committee was necessary. It was then voted that the Secretary write the President and inform him that this County Society is unanimously in favor of and endorses the Minority Report, having adopted the following resolutions: (1) The members of this Society are acquainted with the report and (2) the Society unanimously endorses the *Minority Report.*

Dr. Lawton, representing the Board of Censors,

reported on the applications of Drs. Henry Borow and George Greenberg, both of which were approved, and they were made members of our Society.

The election of a Vice-President to fill the place vacated by the death of Dr. George L. Mack, was next in order, and Dr. Francis McConoughy, of Somerville, was elected to fill this post.

Dr. Lawton reported on the investigation of one Dr. Boas, a chiropractor, and in the employ of the Calco Chemical Co., of Bound Brook, as first-aid man; the Investigating Committee being made up of Drs. Brittain and Lawton. Dr. Lawton pointed out that the Calco Company was desirous of cooperating with the Society in this matter, and said its officers did not wish to have any employee of theirs infringing on the rights and privileges of physicians, but they felt that Boas was free from any guilt in this respect. It was pointed out by Drs. Levy and Ely that Boas has treated patients medically and was, therefore, exceeding his limited license. It was decided to accept the Censors' report, but to investigate further into this matter; but only after the Censors had been given clear-cut evidence of medical practice on the part of Boas.

The meeting was then adjourned.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

Despite the threats of inclement weather to develop into a miniature blizzard, about 75 members attended the meeting on the night of February 8, at the Highland Club, Summit. Dr. Emil Stein presided.

The speaker of the evening was Dr. Josephine B. Neal, Clinical Professor of Neurology at Columbia University, whose topic was "Anterior Poliomyelitis from the Clinical and Pathologic Point of View". The subject was discussed by Drs. Prout, Ripps, Lathrop and others.

The following doctors were elected to membership: George H. Stein, Herschel S. Murphy, Moses B. Radding (transfer from New York), Orcena F. Knepper, Max Ehrlich, Harry Schwartz, Edward J. Moress, Henry Simon, and Simon Daron (transfer from Middlesex).

Afterward, refreshments were served and a social hour enjoyed.

Special Meeting

A largely attended Special Meeting of the Society was held at the Elizabeth General Hospital on the evening of February 15. Dr. Emil Stein presided and presented the first speaker, Dr. Henry O. Reik, Executive Secretary of the State Society and Editor of the Journal, who spoke clearly and comprehensively on the Final Report of the Committee on the Costs of Medical Care of the Sick. He was followed by Dr. J. B. Morrison, State Society Secretary, who in his talk on the same subject fully discussed the Majority and Minority Reports as recently published, in the January Journal. He considered the matter of vital importance and worthy of the most serious consideration of every member of our profession, and he advised the appointment of an able, energetic Special Committee to carefully study the subject.

Dr. Archibald Sinson, of New York, but formerly of Elizabeth, spoke on the English National Health Insurance scheme, or "state medicine" as it exists in England.

Having 2 brothers practicing medicine in England, Dr. Sinson is familiar with conditions there, and he gave assurance that, as now in effect in England, state medicine is not the "bugbear" some of us have supposed.

Others who added to the discussion were Drs. Banker, Green, Schlichter, Beisler, Hubbard, Abel and Mr. Mays, the Hospital Superintendent.

On motion, the Chair was instructed to add 3 members to the County Society Welfare Committee, which was instructed to carefully consider this important subject, from all angles, and to be prepared to make a full report to the Society at its next meeting.

This rather lengthy meeting was marked by the close attention given to speakers by the large audience, and, further, by the fact that discussion was carried on mainly by our own members. Dr. Reik stated, later, that it was of more than usual interest because at similar county meetings held elsewhere, most of the talking has been done by one or more invited guests, often by the members of the "Costs Committee", and in consequence, a full expression of opinion has not been gotten from those most concerned, especially the younger men, in what position shall be taken by the State Society.

Obituaries

Resolutions on the Death of Dr. Powell, Adopted by the Camden County Medical Society

"The members of the Camden County Medical Society have learned with profound sorrow and regret, of the passing of their fellow-practitioner, William R. Powell, M.D., Ph.G., and want to place on record their testimony to his character and achievements.

Dr. Powell, as a medical practitioner, maintained at all times the best traditions of his profession, and his memory will live with those who received treatment from him, and were cheered by his humane and kindly manner. He was a family physician in the best sense of the term, and that always includes the functions of counselor, guide and friend, and in the event of serious illness, especially with its accompanying threat of disaster. He gave the patient and family more than he ever could be paid for, because he gave his kindly self.

Dr. Powell was a man of learning, confirmed and deepened by world-wide travel. He was a true cosmopolite, for every land was his home and every man his brother. He will be mourned by all who knew him.

(Signed) Alexander Macalister, M.D.,
Howard F. Palm, M.D."

WIGG, Cuthbert, of Boonton, died at his home on Lathrope Avenue, on March 2, 1933, after an illness of more than 3 months.

Dr. Wigg, who retired from active practice 5 years ago and gave up all practice 2 years ago, was one of the most popular Morris County physicians. He was born in Lambertville about 87 years ago and came to Boonton at the age of 27. He was a graduate of Bellevue Medical College, of New York, in 1891 and was a member of the American Medical Association, the Tri-County Medical Association and the Morris County Medical Society. He was a Past Master of the local Arcana Lodge and a member of the Odd Fellows Lodge.

Surviving are his wife, Mrs. Laura Jacobus Wigg, and a brother, George Wigg, of Stirling, N. J.

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NURSING SCHOOL ENDS TRAINING OF STUDENTS

(New York Times, Feb. 7)

After almost 50 years of conducting an undergraduate school of nursing, the New York Post-Graduate Medical School and Hospital, 303 East Twentieth Street, New York, is to retire from that field and has under consideration a plan to teach post-graduate nursing, according to an announcement. It was said that the future development of nursing education at the Post-Graduate Hospital would be similar to the post-graduate teaching of physicians, which has been the special field of the school and hospital.

The Directors of the institution will decide that no class of undergraduate pupil nurses will be accepted after next month. The classes now training will be continued and the last nurses to receive their diplomas from the school under the undergraduate arrangement will be the class of 1935. By that time it will have graduated 1438 nurses.

The plan for post-graduate nursing will be developed in conferences with Columbia University officials. It was said that the decision to give up undergraduate training follow recommendations in the recent report of the American Nursing Association, which stressed the fact that there was need of post-graduate education in that field. The committee on the grading of nursing schools reported that in 1900 there was one nurse to every 6405 of the population and, in 1928, one nurse to every 590 of population, an increase of more than 1000%. In 1932 there were more than 2000 training schools for nurses, with 90,000 students, graduating more than 22,000 nurses annually into an already over-crowded profession.

The present school at the Post-Graduate Hospital was organized in 1885 by Dr. Julia McNutt, its first Director of Nurses, and 12 nurses received diplomas in 1888. The school was the third of its kind to be established in New York. In 1895 its Resident Superintendent of Nurses was Miss Annie W. Goodrich, now Dean of the School of Nursing at Yale University.

The late Harris C. Fahnestock provided funds in 1900 to build a residence for the school and since that time William Fahnestock, a Director of the hospital, has provided generous gifts for additions to the residence and for equipment.

SUDDEN DEATH OF THE PRESIDENT OF ABBOTT LABORATORIES, DR. ALFRED S. BURDICK

Dr. Alfred S. Burdick, President of the Abbott Laboratories of North Chicago, Illinois, died Saturday, February 11, of pneumonia, at the age of 66. He was buried the following Wednesday at Rosehill Cemetery, Chicago.

In 1921, Dr. Burdick was elected President of the Abbott Laboratories. The new location at North Chicago had already been selected as a site for the new Abbott Laboratories and when the latter was completed the company moved into these new quarters from the old location in Ravenswood. Meantime the Swan-Myers Company of Indianapolis was consolidated with Abbott Laboratories, thus increasing and extending the business. Most or all of these improvements took place under the presidency of Dr. Burdick. In fact, the comp'eted plant, which is one of the largest and best in the United States, is in many respects a tribute to the genius and wisdom of Dr. Burdick. He had surrounded himself with some of the best executives as well as professional men and thus built up an organization which will continue to efficiently function, notwithstanding Dr. Burdick's premature death.



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Purity of milk supply, sometimes taken for granted, is becoming questionable under present conditions, with farmers in some sections bootlegging raw or improperly pasteurized milk into cities. (See editorial J. A. M. A., Nov. 5, 1932.)

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At the Annual Meeting of the American College of Physicians, held this year in Montreal, Dr. W. Blair Stewart, of Atlantic City, was reëlected for a term of 3 years to the Board of Governors and also reëlected Chairman of the Board.

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ILLUSTRATED CATALOG ON REQUEST

BOX 380, HADDONFIELD NEW JERSEY

A PHYSICIAN'S DIAGNOSIS

(New York Times, Feb. 10)

No more discerning suggestion has been made regarding the cause of our troubled state than that of Dr. Francis M. Pottenger, President of the American College of Physicians:

> Were business concerns to adopt the altruistic spirit of physicians and take less profits or no profits at all from those who are unable to pay for goods, it would soon change the ruthless psychology which dominates modern economic life.

The physician, obeying his own conscience and following the pledge of his profession, responds to every call within his skill and strength to answer. He does not pause to ask whether there will be even a reasonable profit for him or any compensation at all. It will be said that business cannot be carried on successfully on any such basis, even if it has been found practicable in the professions, in the simpler life of earlier days and even in smaller communities today. But if the spirit to which Dr. Pottenger refers as characteristic of the medical profession, in its ministry to human ills without greed or even controlling thought of gain, were as pervasive in the field of business as in that of medicine, we might have escaped much of the economic misery we have been undergoing. What a Utopian world it would be!

As it is, those who in sickness have had benefit of the physician's attention are so often and so quickly forgetful of their obligation that the profession is compelled to look to the adoption of systems which will insure not only universal medical

Continued on page XXII.

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HOSPITAL REVIEWS 5 YEARS' WORK

(Newark Evening News, Feb. 2)

At the Annual Meeting of the Newark Beth Israel Hospital, reports were given reviewing 5 years' service. Since the new institution was opened February 28, 1928, 101,263 patients have received service, including 44,497 in-patients and 56,766 out-patients, it was announced by the Executive Director, Dr. Paul Keller. Of the total patients hospitalized, 55% were Jewish, 28% Protestant and 17% Catholic.

Frank I. Liveright, President, was reëlected, as were the other officers: Vice-Presidents, Michael Hollander and Dr. I. J. Rachlin; Treasurer, A. H. Puder; and Secretary, Arthur Lindeman. New members elected to the Board were George Furst and Leo Weinberg, and Directors elected for 4 years' terms include Louis V. Aronson, Harry Braelow, Nathaniel Elin, Gilbert Falk, Frank Grad, Meyer Krasner, Frank Lindeman and Jacob L. Schwarz.

Mr. Liveright congratulated the Board on its accomplishments in meeting financial problems of the past year, and reported economies of more than $100,000 per year had been effected by pay-roll deductions and minimizing general expenditures. Mr. Puder, in his report, stated that subscribers to the new building who had not made payments due January 1 would be given an extended period to complete payments.

Dr. Keller said that in the 5 years the total number of days' care given was 494,650, including 193,023 ward days' care, and 301,627 private and semi-private days' care. The total of free days' care was 105,992 and the total part-day ward days' care, 87,031.

The 5 years' financial summary of ward service is as follows:

> Ward service in relation to hospital service, approximately 35%, representing a charitable contribution to the community of $1,061,626; ward patients paid toward cost of care, $193,023; balance of actual charitable service to in-patients, $868,603; Community Chest contribution toward ward service, $573,585; balance of ward service costs unpaid by the community, $295,018.

A resolution was offered by Michael Stavitsky and unanimously passed by the Board to record on the minutes commendation of the services of the President, Treasurer and Executive Director.

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DR. MARTLAND TEACHING AT N. Y. U. IN COURSE ON CRIME DETECTION

(Newark Sunday Call, March 5)

Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, is now Associate Professor of the Department of Forensic Medicine of New York University, in which a compulsory course in legal medicine is given to fourth-year medical students in the University and Belleville Hospital Medical College.

"The hope is," said Dr. Martland, "that by education we may create a demand for men trained as medical examiners and toxicologists, so that communities needing such experts will select them in a manner somewhat similar to the way in which they now select health officers."

Dr. Martland's appointment as a professor at N. Y. U. does not mean that he is relinquishing his work here. An ardent advocate of scientific methods in the detection of crime and the head of a bureau regarded as one of the two best in the country, Dr. Martland sees in his university appointment an opportunity to start a far-reaching campaign of education which will do away with the coroner system.

"It is obvious to anyone who has studied the subject with an unbiased mind," says Dr. Martland, "that wherever the coroner's system prevails ignorance, corruption and inefficiency are the rule. One has but to follow in the news-papers the crimes handled by coroners to realize that when the coroner enters the case the confusion and bungling start."

The Department with which Dr. Martland is now connected—he delivered his first lecture there Friday afternoon—was created in January, with Dr. Charles Norris, Chief Medical Examiner of New York City, as professor in charge, and Dr. Alexander Gettler, toxicologist, of New York City, as professor of toxicology.

"The teaching of legal medicine in this country," says Dr. Martland, "is limited to a few lectures to undergraduates in the medical schools on what is called 'medical jurisprudence'. This usually consists of a few lectures on the social and legal relations of the physician, the subject mainly being covered so that the student can pass boards of examiners.

As a rule, they are not even taught what constitutes a coroner's or medical examiner's case. We cannot dignify this as the teaching of legal medicine."

Dr. Martland points out that N. Y. U. has planned and started the following courses: A compulsory course to fourth-year medical students covering salient points as to what constitutes medical examiners' cases, proper signing of death certificates, testimony in court, etc.; an optional laboratory course to fourth-year students consisting of a month's work in a medical examiner's office, assisting at autopsies; a post-graduate course of 3 years in the office of a medical examiner leading to a degree; and a 2-year post-graduate course in toxicology leading to a degree.

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Continued on page XXIV.

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scientific criminologist reaches the solution of a crime.

Working hand in hand with the police and Prosecutor's detectives in his 3 years as County Physician and 5 as Chief Medical Examiner, Dr. Martland has on file many instances in which bungling methods would have resulted in crimes being undetected.

In Essex County it is up to the Chief Medical Examiner or one of his assistants to determine the cause of a sudden death.

"A well-conducted autopsy is the only safe and real method of determining the cause of death," says Dr. Martland. "All other methods are at best guess work."

It was only by means of autopsies that Dr. Martland a few years ago revealed that some deaths were being caused in Essex County by benzol, lead, silicosis and radium poisoning. His papers on those subjects were translated into foreign languages for distribution overseas.

SURVEY CHARGE OF MEDICAL LACK IS NOT TRUE HERE, CRASTER SAYS

(Newark Sunday Call, Feb. 12)

Many thousands of persons all over the United States are needlessly ill much of the time, and other thousands die every year of curable diseases, all because of a lack of sufficient medical care and treatment, according to the chapter on "Health and Medical Practice" of President Hoover's Research Committee on social trends.

This condition may be true in other sections of the country, but does not apply to Newark, Dr. Charles V. Craster, City Health Officer, commented.

"There is no reason for any diseased person in Newark to go along without proper treatment," he said. "There are free clinics to supplement private agencies, and a person who believes he should receive medical care is encouraged to report at the Health Department for examination. More than that, the Department, through public schools and other agencies, is the sponsor of an educational program designed to help residents to recognize dangerous symptoms."

Other points brought out in the chapter written by Harry H. Moore, Director of the Committee on the Costs of Medical Care, also are refuted by Dr. Craster, at least so far as Newark is concerned. Mr. Moore asserts that a large proportion of states, counties and cities are insufficiently supplied with health officers.

"The local Health Department is well manned," according to Dr. Craster, "and I believe New Jersey as a whole stands high in this respect. Urban centers and, in fact, the entire metropolitan section, are widewake to the importance of public health work."

However, the Newark health officer readily agreed with one of Mr. Moore's statements. Stressing the unevenness of the distribution of medical services both geographically and functionally, the

Continued on page XXV.



APPROACH

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F. H. BARNES, M.D.,
Med. Supt.

Continued from page XXIV.

writer stated that there are too many doctors in the cities, and not enough in the rural districts.

"There is no doubt that there are too many doctors in the cities," said Dr. Craster. "It is one of the problems of the medical profession to spread its work more evenly; but it can be solved only by doctors themselves placing service above urban advantages and succeeding the fine general practitioners the rural districts once boasted."

Mr. Moore's chapter is one of 29 sections composing the entire report of the President's Research Committee on Social Trends.

LAW RESTRICTING THE USE OF THE NAME AND EMBLEM OF THE RED CROSS

An Act to amend an Act entitled "An Act to incorporate the American National Red Cross", approved January 5, 1905.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That Section 4 of the Act entitled "An Act to incorporate the American National Red Cross", approved January 5, 1905, is hereby amended to read as follows:

"SEC. 4. That from and after the passage of this Act it shall be unlawful for any person within the jurisdiction of the United States to falsely or fraudulently hold himself out as or represent or pretend himself to be a member of or an agent for the American National Red Cross for the purpose of soliciting, collecting, or receiving money or material, or for any person to wear or display the sign of the Red Cross or any insignia colored in imitation thereof for the fraudulent purpose of inducing the belief that he is a member of or an agent for the American National Red Cross. It shall be unlawful for any person, corporation or association other than the American National Red Cross and its duly authorized employees and agents and the army and navy sanitary and hospital authorities of the United States, for the purpose of trade or as an advertisement, to induce the sale of any article whatsoever or for any business or charitable purpose to use within the territory of the United States of America and its exterior possessions the emblem of the Greek Red Cross on a white ground, or any sign or insignia made or colored in imitation thereof, or of the words "Red Cross" or "Geneva Cross" or any combination of these words: *Provided, however,* That no person, corporation or association that actually used, or whose assignor actually used, the said emblem, sign, insignia or words for any lawful purpose prior to January 5, 1905, shall be deemed forbidden by this Act to continue the use thereof for the same purpose and for the same class of goods. If any person violates the provision of this section, he shall be deemed guilty of a misdemeanor, and upon conviction in any federal court shall be liable to a fine of not less than one or more than $500, or imprisonment, for a term not exceeding one year, or both, for each and every offense."

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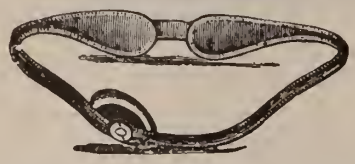
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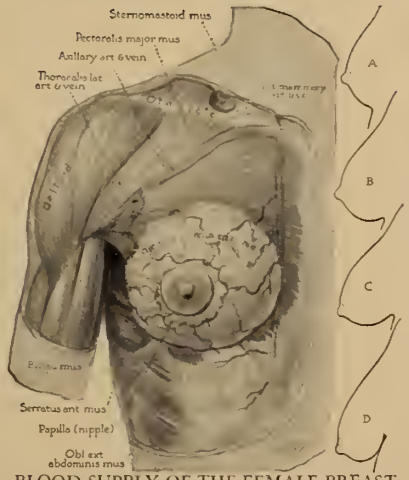
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OF THE

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PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 4 Orange, N. J., April, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

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Viosterol

USE OF VIOSTEROL DURING PREGNANCY

To the Editor:—Please advise me whether administration of irradiated ergosterol to pregnant women could cause a premature calcification of the fetal head, resulting in dystocia, with possibly damage later to the child.

M.D., Waco, Texas.

J.A.M.A., Dec. 19, 1931, p. 1914

ANSWER.—There is no danger to mother or child from therapeutic doses of viosterol (irradiated ergosterol) given during pregnancy. In fact, such medication probably would be of advantage, owing to the excessive drain of calcium and phosphorus that takes place during this period. This medication is especially indicated in cases in which the intake of calcium compounds has been insufficient.

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REPORTS DEATH RATE LOWEST IN 55 YEARS

(New York Times, March 25)

The State Department of Health announced today that new low marks had been reached in the general death rate and the typhoid fever, diphtheria and tuberculosis rates in New Jersey last year.

The general death rate was 10.11 for each 1000 of population, the lowest since the department was established fifty-five years ago. The previous low was 10.63, the mark for 1931 and 1932.

Typhoid fever took a toll of 0.7 per 100,000 population, diphtheria 2.2 and tuberculosis 60.6. While still high in comparison with other diseases, the tuberculosis rate represents a reduction of more than 30 per cent in the last eight years. Cancer claimed an increased number of victims, the rate being 113.1 per 100,000.

A report for February of this year showed scarlet fever and measles more prevalent than during January. There were 3,559 cases of measles, more than double the January figure, and 1,301 cases of scarlet fever, compared with 862 during the preceding month.

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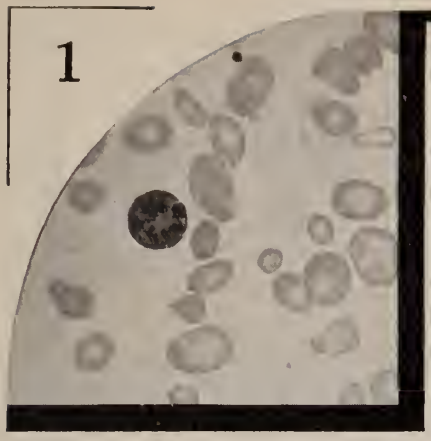
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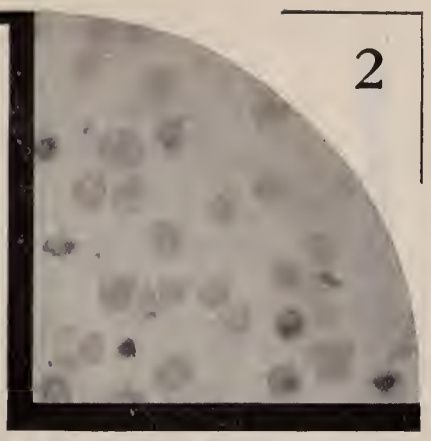
AMSTERDAM BROS.



1

At left—Pernicious Anemia pretreatment level. R. B. C. 820,000 per cu. mm.; Hb. 17%. Started Ventriculin 40 Gm. daily.

At right—Fourth day of treatment. Reticulocytes 54%; R. B. C. 1,120,000 per cu. mm.; Hb. 24%.



2

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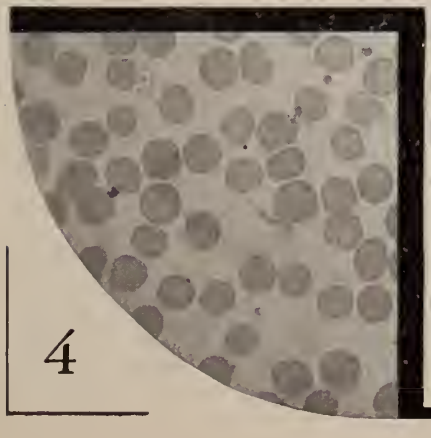
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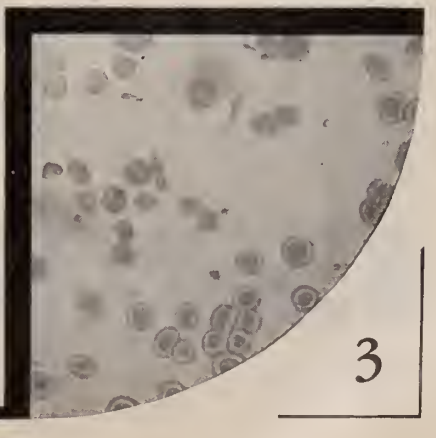
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4

At right — Seventeenth day of treatment. R.B.C. 2,440,000 per cu. mm.; Hb. 56%.

At left—Sixty-sixth day of treatment. R.B.C. 4,610,000 per cu. mm.; Hb. 84%.



3

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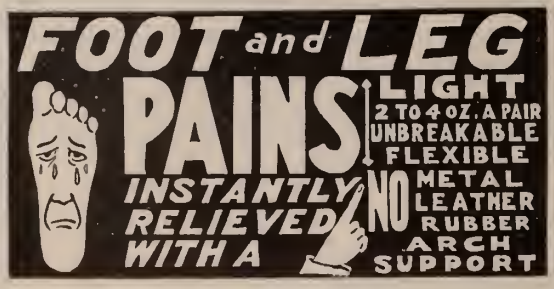
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85-YEAR-OLD FAMILY DOCTOR CONSIDERS PRESENT GENERATION PAMPERED

(New York Times, March 10)

NEWTONIA, Nebraska—The old-fashioned family doctor isn't extinct yet. He lives right here in the person of Dr. H. V. Byers. At the age of 85 years, Dr. Byers has ministered to the ailments of 3 generations and now and again he is called upon to mix his standard croup remedy for the fourth generation. He is not so active as he once was, but he is still in harness.

The medical and surgical practice of 60 years ago are described thus by the doctor:

"Three medicines were about all doctors thought were needed—quinine, calomel and opium. Operations were a simple matter with a few sharp knives, a saw and forceps. Carbolic acid was the only disinfectant available, and if used strong enough to be effective was decidedly painful. Mostly we used plenty of soap and water. Fever thermometers were unknown. You told by the feel of the patient whether he had a fever."

Evidently it was a stalwart generation which survived that kind of doctoring, for Dr. Byers compares it with the present generation to the latter's disadvantage. "People today," says he, "pamper themselves too much. They eat too fast, sleep too little and live too hard. They should take more time and enjoy life a little as they live. Then they'd live longer and happier."

FALSE RUMORS CONCERNING VIOSTEROL DENIED BY DR. STEENBOCK

Ever since viosterol was offered to the medical profession about 4 years ago, it has been attacked by various persons. Some of these attacks no doubt were sincerely motivated, but others were seized upon and exaggerated by interests who had no viosterol to sell.

Recently, a new form of anti-viosterol propaganda has been reported by physicians all over the country. It is circulated by word of mouth—never in writing—and the apparent purpose is to influence physicians to prescribe vitamin D agencies other than viosterol.

Physicians are being told, for example, that Dr. Harry Steenbock has "condemned" viosterol; that the Wisconsin Alumni Research Foundation "would withdraw viosterol from the market in 90 days", etc.

In answer to these malicious untruths, Dr. Harry Steenbock makes the following statement:

"Viosterol in its various forms has to date been found fully as valuable in medical practice as was anticipated at the time that it was first introduced to the American markets. Up to the present time there have been no reports of any untoward effects from its administration, although originally it was anticipated from the results of animal experiments that some cases of intoxication might result from its use in human medicine. * * * I see no necessity for reversing my original opinion as to its outstanding merits in any way whatsoever. Any statement to the contrary can be definitely labeled as false."—(Signed) H. Steenbock.

Physicians can draw their own conclusions and form their own opinions of any house that resorts to sharp practices by allowing its representatives to spread unfounded whispering campaigns against a valuable therapeutic agent that has endured 4 years of the most searching experimental investigation and clinical use not only in rickets but also for controlling calcium-phosphorus metabolism generally.

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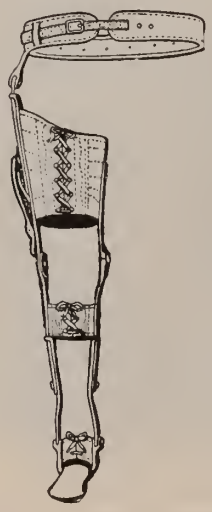
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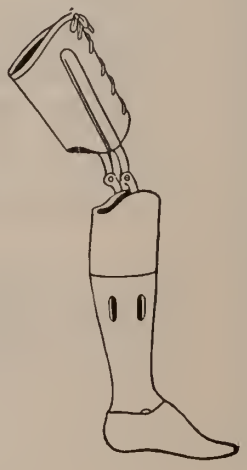
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Journal of The Medical Society of New Jersey

Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Vol. XXX., No. 4 ORANGE, N. J., APRIL, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

MANAGEMENT OF THE RUNNING EAR

George W. Mackenzie, M.D.,

Philadelphia, Pa.

In the whole realm of medicine there is no disease that taxes the skill of the physician more, in its management, than chronic middle ear suppuration. How often does the family physician ignore the running ear or pass it over with the remark that the child will outgrow it? Does not the average patient take the view that so long as his ear is discharging freely and not bothering him otherwise, it needs no attention from the doctor? Is it not the prevailing opinion, even among otologists, that continuance of an aural discharge after a radical mastoid operation is of no consequence? None of these attitudes does credit to the medical profession generally, nor to the otologist particularly. When a patient neglects his running ear until a complication develops, which can prove fatal, his neglect is prompted too often by the opinion prevalent among general physicians, that "nothing much can be done for running ears". This opinion was based upon the failure of men, prominent in the profession, to cure middle ear suppuration years ago, with methods long since obsolete, and doubly ineffective when combined with the limited knowledge of the ear in that period. They even went so far as to claim that continuance of the discharge was desirable, since many patients were known to have developed fatal complications after its suppression.

Since the laity looks upon the doctor as infallible, is it any wonder that it holds no more favorable opinion regarding the curability of running ears than that held by the doctor himself?

In the name of modern medicine and for the sake of humanity, it becomes the duty of the present-day otologist to correct these false notions, not so much by argument as by results that carry conviction with them. A running ear, acute or chronic, is just as curable as a suppuration in any other part of the body, at the hands of the otologist who has acquired some versatility and a willingness to use it in the study of his patients. By versatility is meant that quality which permits the otologist to see beyond the ear, and to consider every factor that could in any way have contributed to the development and continuance of the suppuration, not forgetting the dyscrasias, which are often overlooked.

Speaking of dyscrasias, we must bear in mind the possibility of hereditary syphilis with a +2 Wassermann causing a simple subacute middle ear suppuration to take on the characteristics of a sinus thrombosis. In cases of this kind, antiluetic treatment is indicated more than an operation upon the sinus. Again, the tendency of excessive blood sugar is to produce early facial nerve involvement and other complications because of rapid bone destruction in the course of acute middle ear suppuration, in which case attention to diet will bring about more satisfactory results than dependence upon operation alone.

As a preliminary step in the treatment of a running ear, the diagnosis is most important. When an otologist makes the diagnosis of

"otitis media suppurativa chronica", does he do a whit better than the patient who tells us he has had a "running ear for a long time"? A diagnosis worthy of the name must be comprehensive. It should include an exact knowledge of the following: (1) Every possible etiologic factor. (2) Whether the particular etiologic factor still exists. (3) Have secondary changes arisen locally which can hinder recovery notwithstanding the removal of the etiologic factor? (4) Does any dyscrasia exist to rob the patient of that resistance which is needed to combat the intercurrent middle ear suppuration? (5) Is the diet of that kind which is best suited for the patient to resist suppurative processes? (6) Is the patient getting a sufficient amount of sunlight for calcium fixation, the generation of the maximum number of leukocytes and other resistant factors?

Only after giving the fullest attention to all these factors is the otologist in a position properly to consider the purely local condition. It is the ability to cope with the local factors that distinguishes the otologist from the general practitioner.

Let us review these several factors somewhat more in detail, in the order in which they have been mentioned, as essential to, and not to be neglected in, the treatment of running ears:

(1) Etiologic factors are generally divided into the predisposing and the activating. The predisposing factors are mostly local and include adenoids, tonsils and nasal obstructions of all kinds; the most outstanding being adenoid development. My experience is probably no different from that of other careful observers; therefore, no hesitancy is felt in claiming that the best proof of adenoids being a decidedly provocative factor of ear discharge is that a large number of ear discharges clear up promptly and permanently after nothing more than an adenoidectomy. Enlarged and diseased tonsils no doubt act as predisposing factors, but not nearly so often as adenoids; and, when tonsils do act as a factor, they are usually accompanied by enlarged and otherwise diseased adenoids—which makes it difficult to accept the one factor and exclude the other. As for nasal obstruction, we find in the majority of cases of unilateral middle ear involvement that the side affected corresponds to the side of the convexity where a deviation of the septum exists, and correction of that alone not infrequently results in a cure in cases of not over-long standing. By "over-long" is meant where secondary changes of a complicating nature have already taken place in the middle ear or its adnexa.

(2) It is necessary to know whether or not the above-mentioned predisposing factors have been removed. For instance, the history might tell of a previous operation for adenoids and tonsils. Examination of the throat confirms the history of the tonsillectomy, from which the unwary may conclude, without looking further, that the adenoids were removed too, when in fact they were not. I am reminded of a patient of this kind seen 3 months ago, who had a running ear and complicating mastoiditis, but, worst of all, a compilcating endocarditis with fever. It was a question as to which of the 2 complications, mastoiditis or endocarditis, was responsible for the fever (101°-104°). The consultants, a pediatrist and an anesthetist, both felt doubtful about using a general anesthetic. It was finally agreed to permit removal of the adenoids under nitrous-oxide and oxygen anesthesia. The adenoids proved to be the largest I have thus far removed. The results were satisfactory from every angle, including the prompt clearing up of the running ear. This experience is not confined to a single case, which only goes to prove that the otologist must be careful to look for every possible etiologic factor, even to the point of ignoring the history when it tends to be negative or confusing.

(3) Have secondary changes arisen in the ear and adnexa—for instance, closing off the attic region, interfering with drainage, with resultant stagnation? Some patients develop a gradual disintegration of the ossicles, if not by the impairment of drainage and ventilation, at least materially favored by it. The importance of this form of adhesion is proved by the fact that cases exist in which the suppurative process is limited to the attic and is cured only when attention is paid to this particular region. Adhesive bands are found, too, in the *aditus ad antrum,* where they are prone

to form following an acute exudative catarrh. They favor, more than any other single factor, the development of mastoiditis, should the patient be unfortunate enough to develop an attack of acute middle ear suppuration later.

Caries and necrosis of an ossicle may act as a feeder to the continuance of suppuration. As an accompaniment, we find granulation polyps, which contribute to the impairment of drainage and ventilation. Likewise, fibrous polyps, which are in no way connected with dead bone, can block ventilation and drainage as effectively as granulation polyps or adhesive bands.

Chronic mastoiditis has been emphasized by Dr. Heath, of London, on more than one occasion, as an almost exclusive cause of chronic running ears. He believes so strongly that chronic mastoiditis is the continuance factor in most cases that he is content to pay attention to the mastoid region alone, ignoring the middle ear altogether. He is supported in this by Bárány, who also suggests a modified radical operation in preference to the older, more radical, type.

(4) Does any dyscrasia exist to rob the patient of that resistance which is needed to combat the intercurrent middle ear suppuration? Attention to dyscrasias is very important and, unfortunately, too frequently overlooked, perhaps because they do not obtrude themselves upon our attention. They must be anticipated and looked for. If I were to pass judgment upon one's skill as a physician, the readiness to look for dyscrasias would count strongly in his favor. The dyscrasias are numerous but the more outstanding are syphilis, tuberculosis, diabetes and focal infection. Because it acts in a similar way, I would also include chronic alcohol poisoning.

Syphilis was incidentally referred to earlier. Just how many cases of middle ear abscess go on to further complications, and even fatal termination, because of over-looked syphilis, is hard to estimate. Three cases of sinus thrombosis, one of them terminating fatally, seen in consultation, occurred in patients with syphilis that had not been recognized. Attention to the syphilitic factor alone resulted in the 2 recoveries. Complicating syphilis can exert a modifying influence in several ways and should be suspected in every atypical case, until proved to be absent by a negative Wassermann.

Tuberculosis can act unfavorably in either of 2 ways: by its actual presence in the ear, in which case caries and even necrosis may occur; or by its presence elsewhere in the body, more often in the lung, when it acts much like a focal infection in reducing the resistance of the body to diseases generally, or by inhibiting the powers of repair during an intercurrent attack of a suppurative process distant from the lung.

As for diabetes, I have come to regard it as most important, not so much as a continuance factor as an intensifying one. For instance, if a patient develops a middle ear suppuration and, within a relatively short space of time (a few days), weakness in the facial muscles begins to manifest itself, I become suspicious of a dyscrasia and more often a diabetes than any other, and the percentage of such cases runs quite high. Diabetes has also been found to be a contributing factor to sinus thrombosis. I reported an interesting case of the kind recently.

Focal infection, more often about the teeth, can be responsible for severe complications; besides, it can act as a continuance factor. In every chronic discharge from the ear focal infection should be looked for.

(5) Is the diet of that kind which is best suited for the patient having to resist suppurative processes? The answer has been decided by laboratory experiments on rats by L. W. Dean, while at the Medical School of the Iowa State University. Quoting from him: "In dissecting skulls of animals with eye infections produced by diets deficient in the fat-soluble vitamin, it was observed that in all cases the paranasal sinuses and mastoid cells contained purulent material. These findings led me to suspect that in those animals receiving the low fat-soluble A diet which had died from no perceptible cause, the infection was located in the upper respiratory passages."

I have observed a number of cases of ear discharge which cleared up on a diet rich in vitamin A. In some cases it was administered in the form of cod-liver oil; in others, in the form of half milk and half cream, the latter

because it is more palatable to most patients. I have come to regard fat-soluble vitamin A so important, as an adjunct in the treatment of suppurative diseases, that it has become a standing order to give all children in my service cod-liver oil; whereas, in private practice the same end is accomplished with liberal quantities of half and half uncooked cream and milk. I have not yet come to giving a patient a diet rich in fat-soluble vitamin A to the neglect of attention to the adenoids. If both need attention, and they frequently do, then neither is neglected.

(6) Is the patient getting a sufficient amount of sunlight? This is an important factor, particularly in tuberculous cases, not only when there is local involvement of the ear, but, too, in those cases of purely pyogenic infection of the ear combined with tuberculosis of the lungs. One of the most important causative factors is insufficient sunlight, as proved by everyone who has given tuberculosis any serious attention. The work of Trudeau in this country, and of von Pirquet in Vienna, is conclusive. That sunlight treatment comes nearest to being a specific for tuberculosis does in no way argue against its virtue in other forms of infection. In fact, I have come to use arc light as a form of treatment for practically all kinds of infection, acute or chronic, coming within the scope of otolaryngology. On the other hand, it is not to be regarded as a cure-all to the exclusion of other etiologic factors. It may be that one could manage without it, but I feel confident that my results have been generally better since its installation, 10 years ago, than before.

Attention to all the above-enumerated factors, from (1) to (6), is most important. However, there still remains something to be done locally which interests the otologist especially, and that is, the management of the running ear itself.

Before outlining the form of local treatment which I use in daily practice, brief reference to a symposium on Chronic Middle Ear Suppuration, presented before the Ninth International Congress of Otology in Boston, in 1912, may not be out of place, to show you what a vast divergence of opinion can exist among accepted experts. Everyone interested in the treatment of middle ear suppuration ought to read these papers, not in abstract but in their original form, just to learn how *not* to treat all running ears. Briefly, there were 3 forms of treatment recommended by 3 authorities sufficiently outstanding to be placed on the program. I do not wish to detract from the reputation of any one of these authors. All 3 were no doubt honest and original in their methods of treatment. Dr. Charles J. Heath tried to prove that he could cure the vast majority of cases of chronic middle ear suppuration by his modified radical operation; because, as he believed, most cases of middle ear suppuration continued on account of chronic mastoiditis, for he says that, "disease in mastoid antrum is the usual cause of perpetuation of suppuration in the tympanum". Elsewhere in the same paper he claims that he "saved hearing in 90% by effecting a cure in the middle ear suppuration. The average length of the disease was 6 years." In his statistical table, he reports but 1 fatality in 360 patients operated on.

Dr. Sidney Yankauer, on the other hand, blamed the continuance of the middle ear discharge to patency of the eustachian tube, and devised a set of instruments aimed at permanent closure of the tube. He went on to tell the results: "The total percentage of cures resulting from closure of the tube alone has been 60%; the oldest patient having remained well for more than 4 years."

Dr. Evelyn Nagle saw the problem in an entirely different light. She believed that running ears became chronic because of lowered resistance to the infecting microörganisms, and for that reason advocated the use of vaccines which were beginning to become popular at that time. She claimed to have obtained most excellent results, for in her conclusions she says: "In all, 70 cases have been reported by me during the past 4 years; of these, 60 have remained dry, 5 failed to continue treatment, 2 have recurred, and 3 are still under treatment at present. It must be remembered that many of these were so persistent that radical operation had been advised."

None of the claims of these 3 authors has since been confirmed by others. Of the 3 methods of treatment advanced at that time, the one recommended by Heath has at least

received some recognition, particularly by Bárány, who operates after a method but slightly different from Heath's. We must not lose sight of the fact that Heath recommended his modified radical operation principally for the purpose of conserving hearing more effectually than he believed possible by one of the more radical procedures aimed at the removal of the hammer and anvil along with the granulations in the tympanic cavity. Heath never did answer the questions put to him in 1912 regarding the indications and contra-indications for his particular form of mastoid operation. None of these 3 methods for the treatment of middle ear suppuration ever took deep root. They have been more or less abandoned, and yet there is something to be said in favor of each in carefully selected cases, but more of that for another occasion.

The purely local treatment which I practice is much the same in a general way as that practiced by others; however, in some particulars it differs. The treatment may appear to be somewhat routine and in many ways it is, but not so much so as it would seem. Everything that is done is done for a particular purpose.

(1) Cleansing the ear might mean the same thing to many, but not all of us. Some consider the wiping of pus from the external canal as cleansing treatment. All that such a cleansing accomplishes is a better view of the fundus of the canal. If the canal contains pus, its quantity, consistency, color, odor and every other conceivable quality should be noted and recorded, for the reason that each one has a particular significance. For instance, the odor of stinking feet means cholesteatoma and nothing else; the odor of dead bone means exactly that and nothing else; musty or stale odor means the ear has not been cleansed for a long time and it does not mean cholesteatoma or dead bone. A profuse discharge means something entirely different from a scanty one. A thin discharge generally indicates an unadulterated tuberculous process; whereas, a thick discharge speaks more for a pyogenic infection or a superimposed pyogenic infection. Blood mixed with purulent discharge elicited by slight pressure with a cotton mop indicates granulations. More could be added in this direction if time permitted.

Cleansing the ear ought to mean nothing less than getting rid of secretion which hampers the view of the anatomic details, and no one can make an exact diagnosis without being able to discern them. Better still, the cleansing should go so far as to allow the solution to reach the tympanic cavity if the perforation is not too small. If the perforation is large enough to permit it, a Hartmann's cannula should be used to further clean the cavity where an ordinary syringe might fail.

In some cases, the accumulated detritus includes powders that have been blown into the ear by a previous aurist, and it has become so packed as to make it impossible to get rid of it all at one sitting, even using large quantities of solution. It therefore becomes necessary for the patient to return daily, for several visits, before one can obtain a satisfactory view of the anatomic details. No ear has really been cleansed until it is possible to see the perforation, determine its size, and, when large enough, to permit one to recognize a polyp, if present, its character and size; and, if no polyp is present, to see the ossicles, if still present, almost in their entirety.

As to the best solution to use for cleansing, I prefer a hypertonic bicarbonate of soda solution. I use 2 tablespoonfuls to a quart of water, occasionally combined with some sodium chloride. Since cleansing the ear is done not only to get rid of the stale, odorous secretion from the canal of the ear but also to allow the air to reach the infected mucous membrane lining the middle ear cavity, we must syringe the cavity itself. As a cleansing adjunct in this, we use routinely peroxide of hydrogen solution. The peroxide is used only after the maximal amount of cleansing has been accomplished with the bicarbonate solution. The peroxide solution, when allowed to remain in the ear for several minutes not only cleanses but also cuts loose some free oxygen, which is indeed beneficial in that no bacteria withstand an excess of oxygen well.

An important aid to fuller understanding of the conditions existing in the middle ear cavity is Politzer inflation, which I employ routinely. It informs me as to whether the eustachian tube is patulous and as to the amount of secretion in the tube. In acute, subacute and

chronic middle ear suppuration, it is my practice to use the Politzer bag freely, but I find it even more indicated after operations on the mastoid.

If granulation polyps are found in the middle ear cavity, it is safer to cauterize them than to extract them by force. The best caustic in my hands has been silver nitrate in the form of a very tiny bead. But occasionally I use the solution. I can find no exception to some one else using chromic acid or other caustics. The smaller the granulating area, the less silver nitrate I use and the weaker the solution. I have rarely found it necessary to counteract the effects of the nitrate with sodium chloride solution, perhaps because I am conservative in the amount of the caustic used. To better open the way for the silver solution to reach occluded recesses, a few drops of cocaine solution (10%) are previously used. It is our practice to follow the silver nitrate with 2% alcoholic solution of iodine for its drying and antiseptic qualities. This is mopped out after a minute or two, and a sterilized unmedicated cigarette gauze drain is introduced and the patient dismissed with directions for home treatment; which consists of instillation of peroxide solution 10 gtts., t.i.d., followed by alcohol, 70% solution, for its hydroscopic and antiseptic effects.

Where there are large fibrous polyps, Pregl's iodine solution is used, ½ to ¼ commercial strength, after first using cocaine solution mentioned above. On those visits when Pregl's solution is used, silver nitrate is omitted. In our experience, Pregl's iodine solution fits in especially well for tuberculous patients.

I used formalin solution many years ago and later abandoned it, after having produced a severe burn in one case and a questionable burn in another. Formalin was recommended by Professor Alexander until his recent death.

Where a cholesteatoma is present, as proved by finding the characteristic crystals under the microscope, the use of a Hartmann canula is brought into play in order to lavage the attic antrum region more effectively than is possible by ordinary methods. This is followed by the instillation of alcohol with the head put in the most favorable position for its retention in this region for at least 5 minutes, better still, 10 minutes.

Practically every patient coming for treatment of a running ear is given a dose of arc light before anything else is done locally.

To recapitulate, briefly, my treatment of middle ear suppuration is as follows: (1) Local light therapy. (2) Cleansing the ear after the most thorough manner and according to particular indications with Hartmann's cannula or not, until one can discern all the details that are possible with the otoscope. (3) Shrinking the parts with cocaine. (4) The use of that particular therapeutic agent directly to the middle ear cavity which seems to be indicated; most often it happens to be silver nitrate or some form of iodine. (5) Alcohol to dry the parts and aid in sterilization. (6) Introduction of dry gauze wicks to favor drainage and act as a tell-tale. (7) Home treatment, peroxide cleansing and alcohol, t.i.d.

There are many other forms of treatment, including suction, zinc ionization, and use of solutions containing formalin, which I have tried at odd times, but have abandoned. Much more could be said about treatment, including the operative, but I thought you would be more interested in learning of my particular methods.

CHRONIC SUPPURATIVE OTITIS MEDIA. CONSERVATIVE MANAGEMENT AND TREATMENT

Edward A. Atwood, M.D.,
Paterson, N. J.

The treatment of chronic suppurative disease of the middle ear is dependent upon the correlation of all the data by means of which the cause, subsequent course and present stage of the inflammation may be determined. That present-day treatment is tending more and more to employment of conservative methods is recognized by the majority of otologists. This has been brought about by more careful analysis of the pathologic, anatomic and etiologic factors present, and evaluation of the

knowledge gained by the process of careful history-taking and detailed examinations. Thus, logically, conservative treatment can only be instituted when the exact status of the disease is determined and pathologic conditions requiring radical procedures ruled out.

A carefully taken history will usually reveal the primary cause and place the date of the beginning of the ear infection. Further questioning will elicit information concerning the subsequent course of the disease and bring to light any associated symptoms indicating involvement of contiguous structures such as the labyrinth, facial nerve or meninges. The history alone, in the majority of cases, will determine the subsequent treatment as far as employment of radical or conservative measures is concerned. At the same time, questions should be asked concerning any symptoms arising in the nose, sinuses or throat, and information obtained concerning the general health of the patient.

The various steps of the examination should follow the outline of the history, and must be painstakingly and skillfully carried out. Nowhere is careful and seemingly tedious effort more amply rewarded than in this examination. As a result of a conscientiously carried out procedure, radical remedial measures would be reduced to a negligible minimum. In young children it is not only preferable, but often essential, to administer an anesthetic to properly make the detailed examination on which the success of the treatment will depend, and occasionally during the subsequent course of treatment for purposes of cleansing.

The appearance of the aural discharge is diagnostic, and first should attract our attention. It is most important to note carefully the quantity and character of the discharge, for, frequently, with a benign infection involving only the mucosa, it may be profuse, while in a more serious type, associated with bone necrosis or cholesteatoma, the discharge may be so small in amount that it would pass unnoticed by the patient except for the local symptoms of deafness or odor.

Clinically, it is usual to divide the character of the ear discharge into 3 types: (1) an abundant amount of mucous discharge in the so-called tubotympanic type of inflammation; (2) a thinner purulent type associated with bone necrosis; and (3) a flaky type due to the breaking away of cholesteatomatous particles. The odor of types 2 and 3 is generally fetid, due to necrosis of the bone and lack of drainage. Frequently, with type 2, the discharge is sanguinous because of the admixture of blood from granulations springing from the connective tissue of the perivascular spaces of the bony walls in the process of nature's attempt at repair.

After cleansing of the canal, the drum or remants of this structure can be inspected. Perforations of the tympanic membrane assume a variety of forms, ranging from the small central or marginal perforation to almost complete absence of the drum, depending upon the type, duration and location of the intratympanic inflammation. As a rule, the large central perforations are associated with the milder type of middle ear infection involving only the mucosa, while the marginal perforations presage a more severe infection accompanied by bony necrosis or cholesteatoma. This latter statement is more often true if the perforation be through Shrapnell's membrane leading into the attic.

The second step of the examination is the determination of an etiologic factor located in the paranasal sinuses, the nose, nasopharynx, tonsillar fossae or teeth, for, frequently, the primary cause of the otitis is still present and active in any one or several of these adjacent structures. Lack of attention to this most important part of the examination is directly responsible for a large percentage of the failures in treatment.

Systemic conditions such as syphilis, tuberculosis, diabetes, the anemias, and disturbed metabolic conditions, if not directly responsible, may be constant factors in reducing resistance generally and locally, and must never be overlooked nor their importance underrated.

The result of the treatment of chronic otitis media should comprise 3 aims: improvement of hearing, cessation of discharge, and removal of danger. No hard and fast rule can be laid down for the differentiation between those patients who can be cured by conservative methods and those requiring radical measures. Briefly stated, any pathologic condition out of

reach of local cleansing means, and which is causing symptoms of facial, labyrinthine or meningeal involvement, should be radically treated.

The first step in actual treatment is eradication of all foci of infection or obstructions to drainage in the nose, paranasal sinuses, nasopharynx, or teeth, which have been brought to light by the examination, and attention paid to any general systemic condition which may have a direct or remote effect on the otitic infection. If, however, the cause has long ceased to exist and the inflammatory result alone remains, then local treatment must be actively pursued.

With local treatment, promotion of drainage is the ultimate goal to be attained by the otologist. If the tympanic cavity were regarded as a paranasal sinus with an elongated ostium to which the delicate and highly developed mechanism of audition has been added, the factor of drainage, I believe, would be more clearly appreciated. In this respect, the smaller, frequently high placed, perforations constitute one of the most difficult types to treat. Drainage must be well established by 2 methods: (1) careful catheterization of the eustachian tube, with frequent cleansing of the external canal to remove the products of drainage, and (2) if this does not suffice, enlargement of the perforation is indicated. Patients with large perforations, up to almost total destruction of the membrane, present an easier treatment problem. If polyps are present, they should be removed with a snare or curette without traction, after determining as accurately as possible their origin. The granulating base may then be treated by the application of caustics such as chromic acid, trichloracetic acid or silver nitrate 50-75%.

The problem of providing drainage in all these types of patient resolves itself simply into one fundamental process, and that is *cleansing*. In fact, I believe that all the various methods of treatment in current use are efficacious only in direct proportion to the thoroughness of the cleansing methods which precede their employment. Removal of polyps, granulations, necrotic débris and cholesteamatous masses must be painstakingly and conscientiously persisted in if a cure is to be hoped for.

The use of frequent irrigation I mention only to condemn. This form of cleansing, carelessly and indiscriminately used by the patient on advice of the attending physician—and, I am sorry to say, sometimes of the otologist, who is either too ignorant of the results of such treatment or too hurried to make a careful examination and apply proper treatment—affords temporary amelioration which lulls him into the belief that he is doing something for a condition that can never be permanently cured, and furthers the pathologic condition already present by macerating the tissues, retarding drainage, and increasing the necrotic process.

The so-called dry treatment, by means of gauze or cotton wicks, is open to the objection that it defeats its purpose by damming back secretion, preventing ventilation and macerating the skin of the external ear, with the accompaniment of a chronic external otitis.

Treatment with zinc ionization in a large series of patients in my hands has given most satisfactory results; but again let me repeat that in order that the full benefit from this treatment be obtained, cleansing operations must be most thoroughly carried out, else the electrolytic fluid cannot come into contact with the infected tissues, and herein perhaps lies the efficacy of the treatment—promotion of drainage. Although the process of ionization has been known for the past century, only in more recent years has this method of treating chronic otorrhea received the attention it deserves. That the passage of drugs deep into the tissues of the middle ear by means of ionization takes place, has been well illustrated by the recent result of experiments by Landry, Franquet and Paris, who showed that in rabbits the ionization of $Mg.SO_4$ through an intact drumhead resulted in the passage of magnesium ions into the tissues of the middle and inner ears. The subsequent analysis of the temporal bone showed a marked increase in the quality of magnesium, and it was further demonstrated that daily ionization resulted in an increase of magnesium in the urine and feces which persisted for 14 days after cessation of treatment. Friel in his first studies of

ionization employed zinc because he found it coagulated tissue protein more readily than other metallic salts. This is because of the higher atomic weight of zinc compared to other metals, and its faster ionic speed.

A brief description of the technic of zinc ionization follows: To completely remove mucus and pus which hinder the passage of the ions, the ear is thoroughly irrigated with sterile water, then wiped clean and dry with cotton applicators. The external canal is lightly coated with vaseline to promote insulation and also to guard against the possibility of an external otitis. The patient then lies on the table with the ear to be treated uppermost, and with a medicine dropper the zinc solution, consisting of $ZnSO_4$ 0.5 Glycerine 5.0 Aqua. 100.0, is introduced into the ear until the canal is filled. A special hard rubber or ebony speculum (Yergers electrode), in the center of which a piece of metallic zinc extends, is inserted into the ear so that the zinc dips into the fluid, and this is connected to the positive pole of a galvanic battery. The indifferent negative electrode is applied to the opposite upper arm. The current is then gradually turned on until the meter reads 3 m. a. If the current is turned on or off too rapidly, the patient will experience an annoying attack of vertigo. The duration of the treatment is dependent upon the sensitivity of the patient, the average length of time being 10-15 minutes. The first treatment is usually the most unpleasant, the patient experiencing some vertigo and a burning sensation deep in the ear. After the treatment, the current is gradually turned off and the ear canal is carefully dried. An inspection at this time shows the granulations in the tympanic cavity blanched and shrunken. In the most favorable cases, the discharge immediately diminishes, although often it may be more profuse for 2 or 3 days following treatment. I have found the greatest benefits with this method to be obtained in cases of simple infection of the tympanic mucosa of the tubotympanic type, although other types respond well when the electrolytic fluid can come in contact with the tissues of the middle ear.

As excellent and useful as this procedure has been in the treatment of chronic otorrhea, nevertheless I feel that within the last few years we have had placed at our disposal a method of treatment which is so safe, sure and rapid, simple of application, without any discomfort to the patient, suitable to all ages, well tolerated by small children and, if properly carried out, capable of yielding complete cures in all cases which should be treated conservatively, that it should enjoy more universal employment. I am referring to the iodized boric acid power (Sulzberger) in the form of treatment so well described by Lederman. The only excuses for failure with this method of treatment would be (1) insufficient attention to cleansing methods, with lack of thorough preparation of the middle ear, and (2) its employment in a condition for which a radical procedure is indicated.

The technic, although tiresome and time-consuming if properly performed, is simple of application. Unless this primary principle of thorough preparation and cleansing is carried out, this type of treatment will be foredoomed to failure. Irrigation of the ears should, and often must, be used only by the otologist to remove exfoliated masses of epithelial débris and mucus. The use of the attic syringe is most useful to wash out necrotic masses from the epitympanic spaces, as well as the employment of suction with small tubes, tiny hooks, curettes and cotton wound applicators to take away every vestige of exfoliated membrane. Polyps, if large, should always be snared out, but granulations will quickly disappear when their necrotic irritants are removed. The entire field must then be thoroughly dried by desiccants such as alcohol and ether, wiped out with dry cotton applicators, and, finally, the employment of a current of air to free the cavity of every bit of moisture. The entire procedure of cleansing may well consume ½-¾ of an hour, but time thus spent will pay huge dividends in rapid and satisfying results.

The ear is now prepared for insufflation of the powder. I have never found it necessary to use anything greater than the so-called 1% strength. The action of the powder depends upon the liberation of iodine which, as it is slowly set free, penetrates into the tiny spaces of the tissue of the middle ear. Home treat-

ment is absolutely forbidden except that the patient is instructed to wipe away any discharge with cotton pledgets. The frequency of treatment is dependent upon the severity of the inflammation. At first, treatment may have to be given every other day, but later, not more frequently than once every 5 or 7 days. As long as the ear is moist, the powder completely dissolves in the secretions and never causes any obstruction to drainage. Caking of the powder is the sign of a dry ear, and usually terminates treatment.

I may seem overly enthusiastic over this method of treatment, but when results approach 100% cures, the hearing is improved, and the patient afforded a great saving of time, worry and money, without operative risk, I think you must agree that my enthusiasm is justified.

In conclusion. I should like once more to emphasize the 2 fundamental principles which I have attempted to stress in this paper. (1) A thorough understanding of the etiologic and pathologic conditions involved should be arrived at by means of the proper evaluation of a detailed history and careful examination. (2) The application of logical conservative methods of treatment, based on the exact knowledge gained by means of these processes, although tedious and time-consuming, will result in such a high percentage of cures that more radical methods of treatment will decrease in the proportion to which these principles are observed.

DISCUSSION

(It should be explained here, that Dr. McGivern opened the discussion on Dr. Mackenzie's paper immediately after its presentation and then further discussion was suspended until after the reading of Dr. Atwood's paper; though all discussion is grouped, as here published.—Ed.)

Dr. Charles S. McGivern (Atlantic City): It gives me great pleasure to hear a paper by Dr. Mackenzie because 20 years ago, in Philadelphia, Dr. Mackenzie made instruction in this work possible for a great many men who were hard put to find a source of reliable ear information. Since that time, he has been one of the most active men in promoting the education of aspirants in otolaryngology, and as you all know "Dr. George" is a master of the subject.

His present paper, of course, was limited very largely by the fact that he didn't want to take up as much time as might have been necessary to thoroughly exhaust the subject. He particularly pointed out what I have found to be true in my later practice of medicine; i.e., the influence of the various dyscrasias in causing and continuing ear pathology. There was one he didn't mention that I think is a very important source of ear disturbance, and that is the so-called allergic tendency peculiar to some patients. We find that patients who have hay-fever are apt, in the hay-fever season, to have a recurrence of chronic ear conditions.

I was particularly interested in his calling attention to the discussion in 1912 in Boston, at which were promulgated the vaccine theory of treatment, the Yankauer obliteration of the tube, and Dr. Heath's modified radical operation. We have to remember that the vaccines of 1912 and vaccines today are entirely different. We have a new vaccine, which is little used by otolaryngologists. This vaccine is made after the method and theories of Besredka, and may mean the entire revolution of our ideas as to the nature of infectious processes, because, if Besredka's ideas are correct, or have any basis in truth, then we have not found the real cause of infection. What we see is the external manifestation of germ activity initiated by some other agent which is at present unrecognized.

Dr. Mackenzie made no mention of the possibilities offered by medication through the eustachian tube, but I have sometimes had gratifying results following treatment of middle ear conditions by injection through the tube of alcoholic solutions, and particularly alcoholic mercurochrome. This solution seems to have the virtue of adhering to granulation tissue and exerting an antiseptic action for a long period of time. Injected into the middle ear through a catheter, it seems to offer an effectual means of treating at least a small minority of cases. Naturally, as Dr. Mackenzie has pointed out, the main thing is removal of the cause. Anything else is superfluous, until this is accomplished.

I don't know of any paper, on the management of the running ear, that I have heard that was as complete and as well-rounded as this one.

Dr. C. H. Littwin (Hackensack): I would like to ask Dr. Mackenzie if he has had any experience with the iodine dusting powder?

Dr. J. Wallace Hurff (Newark): I wish to take this opportunity to thank Dr. Atwood for his interesting and complete discussion of chronic suppurative conditions of the middle ear. I do not think I can add anything to what has already been said concerning the preparation, examination, or treatment, especially the conservative treatment of these cases.

As one reads the literature on otology for the past few years, one is impressed with the fact that the treatment of chronic suppurative otitis media has been the battleground of otologists for years and that in all probability the discussion will continue for a long time. As doctors, I don't think we are any different from other professions in that we all have our inclination toward being conservative or radical. When I am confronted with this type of patient, I often recall a conversation I had with Dr. Barkhorn, in which he said he did not want to be a radical conservative, but would rather be a conservative radical. I have found this motto useful, and have tried to live up to it in my practice of otology.

In considering the results of those advocating conservative treatment as compared with those advocating more radical methods, there is a great diversity of opinion. I think this is due to the fact that we have not been explicit in describing the type of case with which we are dealing. Taking a group of suppurative otitis media patients, we first have to exclude those who require surgery. Im-

mediately this is done, we exclude at least 50% of the chronic suppurative otitis media conditions. Of course, the surgical cases are not under discussion. That narrows the group down to the distinctly conservative and the borderline types.

I think the profession as a whole agrees that the so-called tubotympanic type, where the mucous membrane alone is involved, is certainly a type for conservative treatment. The instant you get beyond that, to involvement of the mucoperiosteum, bone, formation of polyps, formation of granulations, your percentage of cures is going to fall off rapidly. At least that has been my experience, and at this stage, there is the ultimate danger of carrying conservative treatment too far.

I agree with Dr. Atwood when he says the more thoroughly we study the causative factors and existing pathologic conditions, the more we will appreciate the possibilities of conservative treatment.

Another point is the question of cures. Is it right to consider, after a given period of conservative treatment, and when the ear has become dry, that the ear is cured? The condition has been abated. It is probably cured in so far as nature can repair it, but potentially, that ear to some extent is still a dangerous ear.

Dr. Henry C. Barkhorn (Newark): Of course, we in Newark, on account of the nature of Dr. Eagleton's work, see the cases which go bad, and we feel very definitely that aside from the frank intracranial infections that need an operation absolutely, those patients who have occasional attacks of headache, dizziness, and vomiting, without a background such as migraine, are heading toward trouble and also need radical operation.

Dr. Mackenzie's paper is splendid. His criteria of the nature of the discharge as showing the etiologic background is splendid for teaching purposes, but if we follow it slavishly, we will get into trouble. You can't tell from the nature of the discharge what is behind the remnants of the drum or in the eustachian tube; you can tell from headache, vomiting or dizziness.

The same with Dr. Atwood's proposition that when the powder begins to crust you have a dry ear but not a safe ear. That is what we did with boric acid 20 years ago—when the powder began to crust we had a cork which was concealing our evidence, and we had trouble.

It is gratifying to have everybody return to the old proposition that we want a dry ear as well as a safe ear. For a long while, in teaching, we were doing sloppy radicals. The teaching was that we were after a safe and not a dry ear. It is essential that we realize that we must get back to the old rule.

Dr. J. A. Fisher (Asbury Park): Just a couple of practical points along the line of running ears that we might overlook in some of the cases difficult to cleanse: After hearing Dr. Lederman's description of his technic for the Sulzberger iodine treatment, it was necessary to devise a method for thorough cleansing, as Dr. Atwood has pointed out. It occurred to me that we have many methods of irrigating an ear after we arrive at the stage where we must get rid of all the necrosis or débris, and that we must have some safe method of irrigating without using too much pressure, and yet withdrawing everything from the external and the middle ear so far as possible. Therefore, I struck upon the Becton-Dickinson syringe, with the patient in the horizontal position and the ear uppermost, and by gentle suction in and out, I was able to dislodge particles that I could not wipe away. Also I could aspirate back into the little syringe the particles which probably were washed in and around from the middle ear to some extent, that is, after I had done the irrigating with the cannula in the upper tympanic spaces. I found this method of irrigating and cleansing to be the most efficacious. You could always see every landmark.

One more type of patient, and that is the type with a heavy, thick, tenacious mucus that is so hard to dry and eradicate. To dissolve out the mucin, the bicarbonate solution helps to some extent, but a solution of caroid would liquify this to the point where there is no further mucin present. Then you can follow out the cleansing and drying. I am strongly for the Lederman technic as outlined by Dr. Atwood.

Dr. Charles S. McGivern: I was much interested in Dr. Atwood's paper, and particularly his reference to the so-called tubotympanic type of middle ear suppuration. You don't have tubotympanic suppuration of the middle ear if you clean up the environs of the tubal orifice and get it open.

So far as treatment with packs is concerned, there is a type of pack that he did not touch upon. I refer to a pack continuously wet with an antiseptic solution such as alcoholic mercurochrome. I use it constantly. This not only keeps the canal open and facilitates drainage, but it also hardens the skin of the canal so that not only is infection that might take place there apt to be discouraged, but that which is there is apt to be cured.

Dr. Mackenzie, I think, wrote his paper on the basis that one excluded all possible complications from the ears he was about to treat. If he has a patient with vomiting, headache, or dizziness, naturally he will not treat conservatively. Is that your point, Dr. Mackenzie?

Dr. Mackenzie: Yes.

Dr. McGivern: The operative cases were entirely eliminated; you did not advocate this form of treatment for anything but drying up the ear.

Dr. Mackenzie: That is right.

Dr. McGivern: It is particularly not safe in the presence of other symptoms. We know that an ear is not safe merely because it is dry.

Dr. Mackenzie: That is so.

Dr. Edward A. Atwood (closing discussion): First of all, I don't want to convey the impression that I never operate for the cure of chronic otitis media. On the contrary, I consider it most necessary, in certain pathologic conditions, to operate in order to obtain a cure. In the presence of symptoms pointing to involvement of the facial, the meninges or labyrinth, I don't believe conservative methods should be employed, excepting perhaps for the occasional patient in whom, because of great bone destruction, cholesteatomatous masses in the attic or antrum, causing labyrinth irritation, are easily accessible for complete removal and the establishment of drainage with subsequent epithelialization of the cavity. These patients must be individually considered and differentiated. They are the borderline types of which Dr. Hurff spoke. The results of the examination will usually exclude the type not amenable to conservative treatment.

Secondly, we must consider the method or process by which healing is obtained. After all, when we perform a radical mastoidectomy, how is healing obtained? By one of two methods: either by employing a skin graft or allowing the cavity to

epithelialize itself. Both attain the same result. If, then, we use that same method in treating these relatively large cavities involving the attic and antrum, and obtain the same end-results of epithelialization and drainage, I can't see the difference between the procedures. Epithelium will exfoliate, no matter whether it is on the scalp, the skin or in a radical mastoid cavity, and these radical mastoids must be periodically cleaned after they are performed. The same process and treatment hold true with healed otitis media, and, if sufficient drainage is present, the result is as safe an ear as the one radically operated.

The employment of x-rays is a necessary procedure in checking up all cases of chronic running ears. It should never be neglected.

Answering Dr. Barkhorn, when the powder dries, it usually terminates the treatment. I make it a rule to carefully clean it out, so that it does not act as an obstruction to drainage.

The continuous pack is all right if it could be carried out by the otologist whenever it needs changing. I would advise against any home treatment except in conditions which, perhaps, are not dangerous. I am in favor of having all of these treatments carried out only by the otologist because he is the only one capable of assessing the proper values of the condition found in the middle ear.

Dr. George W. Mackenzie: The purpose of my paper was to present something about the treatment of middle ear suppuration, the treatment of running ears. I did not take up the question of the intracranial complication because I did not think it pertained to the paper. On the other hand, I can appreciate how some of you may have wished that I had taken it up. It is really important in the treatment of cases, and as one speaker brought out, we want to be able to anticipate intracranial complications.

I could have gone on to that. For instance, if the patient developed vertigo in the course of middle ear suppuration, you would naturally examine his eyes to see whether he had nystagmus. He might not have any nystagmus at the time you examine him, but he might have had it an hour or two before. You should not only observe the fact that nystagmus is present, but you want to know something about the direction of it. In these suppurative cases you will usually find the nystagmus directed toward the affected ear; in destructive conditions, away from it.

In most cases where you find that the patient has repeated attacks of irritative symptoms, cleansing the ear thoroughly causes their abatement for a time, until more detritus accumulates after a few weeks, and with the recurrence of the attack you notice the nystagmus again directed toward the affected side. Then we come to the conclusion that the patient is prone to anything in his ear, and you cannot depend upon the conservative treatment of cleansing alone. The patient then should be operated on, after that particular method which is indicated by the duration of the discharge. For instance, in an acute running ear you would operate after the simple methods. A longer lasting one you would operate after the more radical ones.

I was pleased to hear someone refer to the conservative operation with the vulgar term of "sloppy". The conservative operation has a place, but we must not forget the more thorough, complete, radical operation.

I want to thank Dr. McGivern for his liberal discussion. I have not yet used alcoholic mercurochrome in the eustachian tube, but I can find a place for it, and I am going to try it.

As to the allergic theory, those ideas are new. They are still on trial, but they seem to offer considerable promise, and I am interested.

As to the iodine dusting powder, I have not used it but I have used iodine vapor.

Dr. Littwin: I mean Sulzberger's iodine dusting powder.

Dr. Mackenzie: No, I have not used that. I have used the iodine vapor, and thought I got some results with it. I am strong for iodine in all suppurative conditions, particularly if there is a remote tuberculous basis.

Really I wanted to bring out more particularly the importance of making an accurate diagnosis, and by every possible method that we have at our command, using also the specialists in every line, and the laboratory, in assembling those particular things which the otologist knows better than others do, in evaluating them, and determining which is the antecedent, if we can, and treating the cause wherever possible, unless secondary conditions have arisen in the ear which require particular attention, when we will have to treat that secondary cause first, and then give attention to the etiologic factors.

PROBLEMS IN MODIFIED AND RADICAL MASTOID OPERATIONS

Charles W. Buvinger, M.D.,
East Orange, N. J.

Among the problems arising in modified and radical mastoid operations, those to which I shall limit myself in this presentation are: (1) Causes of delayed healing; (2) reasons for not securing a dry ear; and (3) the hearing problem.

At the commencement of my mastoid work I have been led to believe that the radical mastoid operation not only prevented intracranial complications but also relieved the patient of that annoying symptom—a running ear. Anyone reading the descriptions in standard textbooks on otology would have reached the same conclusion. However, if he critically examines his own work, and that of others in the same field, it will be forced upon him that a varying proportion of patients do not secure dry ears; and that some of those who do, must be subjected to a large number of after-treatments.

Quoting from Sir Charles A. Ballance's book—"On the Surgery of the Temporal Bone"—(Vol. 1, p. 213): "Whiting, in his work published in 1906, speaks of the severity of the pain inflicted by dragging out the gauze

packing, and of the weary weeks of frequent dressings and irksome details which the intelligent care of mastoid cases require." Politzer says: "The duration of the after-treatment varies from 6 weeks to 9 months and over. The mean duration is between 3 and 4 months." Grunert says: "In *exceptional* cases cicatrisation proceeds so *smoothly* that the entire cavity is healed in from 4 to 6 weeks; on an average it is complete in 3 to 4 months." There are, however, especially unfavorable cases in which, either as a result of constitutional peculiarities or of particularly unfavorable local conditions, this period of time becomes considerably extended. Passow, in a thoughtful paper, gives statistics from various clinics showing that the average duration of treatment by the tamponing method varied, from 4 to 10 weeks in the most favorable instances, up to 36 weeks and over. Respecting the most favorable figures quoted, he (Passow) says: "Though Hartmann, in the most recent edition of his text-book, when referring to the radical operation, remarks that the healing takes from 4 to 10 weeks, this can really only be taken with a grain of salt." Quoting again from Ballance: "A visit which I (Ballance) paid a few years ago to the Otologic Clinics of Körner, Lucas, Trautmann, Jansen, Schwartze and Grunert, Barth, Politzer, and Bezold, in which I saw hundreds of patients in various stages of treatment by the tamponing method, gave me the impression that the above quoted statements give rather a too favorable view of the results. I should say that in many of the cases treatment was continued for 6 or 7 months."

With the results reported by Ballance from this array of otologic talent, one is not entirely discouraged if his own experience corresponds. However, the average time taken seems too long.

(1) *The causes of delayed healing* have been earnestly sought. A prime cause may be failure to remove small areas of diseased bone. But, even when one feels confident that complete removal has been done, the healing is still delayed.

A second cause is failure to lower the facial nerve ridge sufficiently, so that the lower skin flap, instead of being smooth, rides in a hump over the ridge and gives out exuberant granulations. Failure to remove the processus cochleariformis on the inner wall of the tympanum, is a third cause; indeed, some years ago Kopetsky gave this as the chief cause. A fourth cause is failure to secure closure of the tympanic end of the eustachian tube; but this is debatable, for about half of the "Vienna School" operators say that procedure is not necessary.

The above mentioned reasons are anatomical and concern the thoroughness with which the operation is done, but, granting that the operation has been complete, and all of the technical points have been complied with, still healing is often delayed.

It is my own experience that the cause for delay is: Granulations forming deep in the angle between the roof of the tympanum and the sloping bottom, or internal wall, of the surgical cavity. These granulations push forward, over the eminence of the external horizontal canal; push forward over the stapes in the oval window; unite with a tag of skin from the roof of the bony canal, and, almost over-night in some cases, form a secondary drum. The result is that one has a tympanic cavity closed off in its upper half or upper third, with membrane, and filled in behind with granulation tissue which continues to secrete pus. There may be a small hole in the lower portion over the tube area. If the patient is only seen every other day, these granulations become prominent, as a rule, in spite of our best efforts. One way to prevent them is to see the patient every day and, as fast as the granulations appear, cauterize them, pinch them off, or pack tightly; though the latter is very annoying to the patient. This formation of a secondary drum is much less likely to occur if the annulus tympanicus is completely removed.

(2) *The causes of not securing a dry ear.* Where the modified radical has been done, the proportion of dry ears is very low, due to the impossibility of removing all the granulation tissue in the middle ear; inability to remove the processus cochleariformis; inability to clean out the cells around the eustachian orifice and in the hypotympanum; and failure to close the eustachian tube. However, where the hear-

ing is good, or just a little diminished, we believe an attempt should always be made to heal the ear without disturbing the drum and ossicles.

It would seem that if some method could be found to induce the surgical cavity to heal over rapidly, much of our difficulty in securing a dry ear would be prevented.

Quoting again from Ballance: "As far back as 1886, Urban, of Leipzig, mentioned Thiersch's method of transplanting large epithelial grafts." Siebenmann, in 1893, was the first to mention the use of Thiersch's grafts in the radical mastoid operation. Ballance himself seems to have been the first to advocate the systematic adoption of epithelial grafting for immediate healing of the bone wound, in a paper published in 1900. In his "Surgery of the Temporal Bone", he was still strongly advocating the method as a means of cutting down the healing time of radical mastoid wounds; and so far as I am able to discover, he still is advocating the same method.

Skin grafting has been tried by many in America, but only continued in use by a few; given up generally because of failures or because of the inherent difficulty and tediousness of the operation. Reading the description of skin grafting one would think it an easy operation, but on attempting it one soon discovers it is not. That is no reason, of course, for not acquiring the patience and the technic to cut and apply a proper graft. First of all, one needs an assistant to pucker up the skin into a fold, and a large, hollow-ground, sharp, graft-knife, to be held at the base of this fold by the operator. The skin is pulled by the operator's other hand from under the knife, the graft thus being caused to ride up over the blade. As *thin a graft as possible* is the desideratum. The graft is held in place with small Kelly sponges, prepared in advance especially for the purpose.

Dr. Harris P. Mosher described (Paraffin Basket Mould for Applying a Skin Graft to the Radical Mastoid Cavity, Trs. Am. Otol. Soc., 1925) the method used at the Massachusetts Eye and Ear Infirmary, and at the Manhattan Eye and Ear Infirmary, and which is highly thought of by many other otologists.

It will be noticed that nothing has been said about the "skin flap". It is the writer's opinion that it does not matter what flap is cut: a Panze horizontal T, or some of its modifications; the horizontal Y flap of Siebenmann; the broad strip flap of Körner; or any other elected method, provided: (1) The operator first skeletonizes the membranous canal; i. e., cuts away all muscle and overlying connective tissue. (2) Provided a small piece of the deep inner or lower corner of the upper flap is cut off, because, if not cut off it will be found to hang loose and from it will spring exuberant granulations.

Lately, the writer has been using the broad-strip-flap of Körner, because it does not have the deep inner corner of skin to contend with (forming granulations) and there is left a smooth surface at the external orifice of the ear, which is an advantage when it comes to doing the dressings, since a large speculum can be inserted without causing pain. In all other methods of flap cutting a raw surface is left on the posterior edge, which causes a great deal of pain during dressings.

Summing up, one can say that the best chance of securing a dry ear in a short time depends upon: (1) Thorough eradication of all diseased tissue. (2) Application of Thiersch grafts. (3) Treating the wound by the dry method, that is, the insufflation of some antiseptic powder such as boric acid, aristol or iodobor, and the use of little, or no packing. Where the skin graft only partially takes, this dry method will be found especially helpful in securing healing.

The foregoing statements apply only to the complete radical mastoid operation. Where one endeavors to preserve the hearing by not touching the bones of the middle ear, a moist ear is almost certain to result, due to the persistence of a discharge from the eustachian tube; which can sometimes be cured by irrigations with mild silver nitrate solutions.

(3) *The hearing problem* often delays a radical mastoid operation that, otherwise, should be done. There are those who still insist that a complete radical mastoid operation will not lower the hearing and will, in a certain number of cases, improve the hearing. Such have not been my results. The usual findings are: One group hearing 2 feet be-

fore and 2 feet after operation; another group hearing 6-8 feet before, and 2 feet after operation; and the conclusion that taking out the malleus and incus drops hearing to 2 feet for conversational voice. While this is a great handicap, it is in part compensated for by the knowledge that a focus of disease which might cause meningitis, sinus thrombosis or brain abscess, has been eradicated.

DISCUSSION

Dr. Charles Franklin Adams (Trenton): Dr. Buvinger has given a very frank survey of the results of the radical operation on the mastoid bone. The eradication of all necrosed or cancellated bone must be thorough. Closure of the tympanic end of the eustachian tube may not hasten healing of the primary operation but it does tend to keep the ear dry after it has healed.

A modified radical operation was introduced by Heath some 20 years ago, and was presented to the International Otological Congress, in Boston, in 1912. It was discussed and condemned by the delegation from England. Heath claimed that all this suppuration was dependent on infection in the mastoid antrum and he put up such a good defense that he was invited to operate on a number of patients in the Massachusetts General Hospital. Mosher and Plummer made a report on those operations afterward and decided that the claims made by Heath were not substantiated (Loeb's Operative Surgery of N. T. & E., Vol. 2, p. 357). Loeb believes that this operation may be used on children up to 10 years of age, even if the discharge has lasted for several years, and particularly if the functional tests show good hearing.

In bilateral chronic suppurative disease, the modified operation should be performed on the ear which shows the better hearing, while the usual radical may be performed on the other side. The method requires opening of the mastoid process, particularly the antrum and aditus ad antrum, as far inward and upward as the annulus tympanicus, without disturbing the ossicular chain. Thus, a communication is established between the aditus and middle ear, sufficient to permit air and water to be forced through. The posterior bony canal wall is removed to 1/16 in. of the annulus. The posterior portion of the membranous auditory canal is split, and a flap made is sutured to a previously prepared periosteal flap. The primary skin incision is made just at the junction of the auricle and mastoid area. The incision posterior to the auricle is sutured in any way desired, and drainage is accomplished by means of the opening into the mastoid, through the posterior canal wall. Care should be taken not to place any gauze or drainage material against the tympanic membrane. After a few days the mastoid wound is cleansed with cotton and the tympanic cavity cleared of exudate by forcing blasts of air into and through the aditus by means of a rubber bulb and a special cannula, which may also be used for the introduction of watery solutions for the same purpose.

Not infrequently one meets in young people border line cases of chronic mastoiditis, in which this operation may be used with success; but it is not suited for cases wherein there has been severe destruction in and around the annulus.

J. Morriset Smith (Arch. Otolaryn., 1931, 13:28) says: "When the malleus and incus require removal, and the posterior wall of the canal is intact, there should be a complete exenteration of the diseased structure in the mastoid and middle ear, without removing the wall of the canal." This avoids the cavity flap of the radical operation, and the hearing results are improved.

Dr. George W. Mackenzie: There are only 2 points that I would like to discuss. With regard to cleaning out the region of the processus cochleariformis, as recommended by Kopetsky, I noticed that the essayist neither recommended nor condemned it, but I want to condemn it, if I may, upon the basis of anatomy and pathology. (Much of Dr. Mackenzie's discussion was so intimately associated with blackboard drawings that it is difficult to understand when detached, and, in consequence, is not here reproduced.—Ed.)

I have performed a few labyrinthine operations and have been careful to preserve the canal in this region. We have the external semicircular canal above it, and use this as a protection according to the Neumann operation which I have, however, modified somewhat, but which is no more radical. Here, we uncap the promontory, unite the oval and round windows into one until we see cerebrospinal fluid emerging. Concerning those cases in which I have preserved the facial nerve in this part, in 50% there was a facial nerve paralysis afterward because of too liberal thinning of the bone up in this portion. Nor am I ashamed to report 50% of such results in a large series of 40 to 50 labyrinth operations, since Neumann reported that he had operated on 3 patients at the Massachusetts Eye and Ear Hospital, and in all 3 cases there was paralysis of the facial nerve, though he said beforehand that a man should not have a facial paralysis following a labyrinth operation.

There is one other thing—the hearing—after a radical mastoid operation, that is important. When I first became acquainted with radical mastoid work it was by working as an aspirant at the Politzer Clinic. I saw a great many operations performed by Politzer himself and his 3 or 4 assistants. I saw Thiersch grafts sometimes successful, but more often unsuccessful. From study of a large number of cases, the consensus of opinion of those 4 or 5 men was: that following their most radical mastoid operations—the Kuester-Bergmann method—about ⅓ were improved in hearing afterward; in about ⅓ the hearing was neither improved nor impaired; and, in ⅓ the hearing was reduced. Of course, those patients were treated after the operation, by assistants, and of course they were not treated as Politzer would have done it. I have seen Politzer treat a patient after such an operation, the poorest-looking Galician Jew, and give him the most careful attention for 15-20 minutes, as only a *great man* can do it, and he got results; but the others who did not want to handle them, or just handled them indifferently, did not, of course, have such good results.

In private practice, I find very few patients who are not hearing better after the thorough radical mastoid operation, but I find a vastly larger number actually improved, in spite of the fact that the malleus and incus have been removed.

I might say that I always obey the admonitions of these great men—never to curette the median wall of the tympanic cavity.

Dr. Lyndon A. Peer (Newark): I would like to know how the Thiersch graft is applied in the mastoid cavity? Are a number of small grafts, or a single large one, used? How much pressure is placed over grafts?

Dr. Charles W. Buvinger: I will answer Dr. Peer's question first. In cutting a Thiersch graft

and applying it to the radical mastoid cavity, one tries to get a graft as large as he can, and apply it to cover as much space as he can. I see a smile on Dr. Mackenzie's face, and I know he has tried it. You frequently find you start out with a large graft and you end up with smaller ones. It has been my experience that it will take 4, 6 or even more grafts to cover as much cavity as you want, and personally I apply as much pressure as I can reasonably get through a small Kelly's sponge to get the grafts to stay, and then I don't touch them for at least 5 days, and if they don't smell too much I even let them go for a week. Then I wash them out with peroxide and alcohol, as has been recommended previously.

I want to take exception to my good friend, Dr. Mackenzie. It was under his guidance that I went the first time to Vienna back in 1927, and I have good reason to thank him. I have been there several times since, but I do want to take exception to what he said about the middle wall of the tympanic cavity. That is dangerous ground, that is true, and if you put a chisel in between the niche of the oval window and the round window, as our friend Neumann recommends, and give it a sharp blow with a hammer, off comes the top of the promontory, and the first turn of the cochlea, and possibly a part of the facial nerve comes with it.

But we are not discussing labyrinth operations today. If you have your granulation tissue pretty well cleaned out before you go into the eustachian tube, use some adrenalin packing, and have a good light so you can see every step of the way, and then if you take a Richard's curette, and your touch is accurate, which I assume it is, you can remove the processus cochleariformis without touching the facial nerve, by having the anesthetist watching all the time.

As to the hearing problem, I knew that somebody was going to say something about it: The hearing is improved; in fact in all the textbooks it says that. My series is not so large, but what it is I will give you: I perhaps have one or two people who think their hearing is improved a little. I, personally, can't see with a radical operation where it does improve or can improve hearing if you take out the bones. Those statistics that I quoted I did not say where they were from. They were the statistics which were quoted by our friend, Prof. Ruttin, from a thousand consecutive radicals in Vienna from the Vienna clinics. I didn't say that in the paper, but I will now; they are Ruttin's statistics, and they practically agree with my own. My own results are that the hearing is rarely improved, and usually it is cut down. I always tell a patient that is going to submit to a radical operation that he will probably lose a large proportion of his hearing. When they need it, they need it: and there is no use delaying until they get a brain abscess, or meningitis or sinus thrombosis.

THE CHILD WHO WILL NOT EAT

Sandor A. Levinsohn, M.D..

Paterson, N. J.

The child who will not eat is a problem concerning which much has been written during the past 10 years—so much in fact, that the subject may appear hackneyed. The problem, however, is so universal, and so time-consuming to the practicing physician, that it holds an ever-present interest. It is with the hope of perhaps crystallizing some of the latest accepted views concerning anorexia nervosa, that this paper is presented.

The child who will not eat is ubiquitous. Scarcely a day passes that one or more such children are not brought to the physician's office by despairing mothers. This type of child has been estimated to constitute from 50% to 85% of all children seen in private practice, yet it represents a problem which has developed during comparatively recent years.

The question of anorexia has been studied from many angles and varied causes for it have been described. To mention only a few would include anemia, lack of vitamin B, excessive milk feeding, gastric ptosis, mucous gastritis, hypoglycemia, hypo-adremia, unbalanced diet and infections. When all is said and done, however, while physical causes for anorexia undoubtedly exist, it is unreasonable to suppose that such a large percentage of children as suffer from lack of appetite can also be suffering from so many serious organic complaints. This seems particularly true if we stop to consider that the vast majority of children who will not eat are found among the so-called "better-class" families, and are well cared for and the subjects of frequent periodic examinations by physicians. The children of large families in poorer circumstances, and the inmates of orphan asylums and other institutions, usually have good appetites, and it would be illogical to assume that the vast majority of children under regular medical care would develop serious organic and nutritional disturbances from which the children of the submerged classes would be exempt. Is it not more reasonable to believe that the very care and solicitude which is lavished on the better cared for children result in a functional disturbance which is psychogenic and which does not affect children not surrounded by care and over-protection?

It is, therefore, with this premise that one should approach this subject—that the child who will not eat, in the majority of cases, represents a form of conduct disorder, and treat-

ments should be psychologic rather than physiologic.

Our problem is to develop each child up to and beyond a theoretic average for the particular child at hand. Height and weight tables are futile and generally incorrect, since such factors as race, family-build, and constitutional tendencies cannot be ignored. A child's state of nutrition must be judged by his color, turgor, activity, etc., and to attempt, by forcing him to eat, to arbitrarily make a child gain weight (if he happens to be below average according to the tables), is a mistake, and is often in itself the cause of chronic anorexia. Caloric feeding must be discarded and individual needs and desires must be respected. Those children who eat and enjoy their food acquire not only physical perfection, but also nervous stability, which is of even greater importance. To eat with enjoyment implies the existence of appetite and this leads us to a discussion as to what constitutes hunger and what constitutes appetite.

Though possibly elementary, a definition of these terms is necessary to avoid misunderstanding. Hunger may be considered as a disagreeable, almost "painful" sensation, due to the contractions of an empty stomach. It results in no production of digestive juices, and therefore does not aid digestion. It produces only a consciousness of the need of food. Appetite, on the other hand, is a pleasant desire for food associated with a memory-sense of enjoyment. We can have no appetite for a food we have never tasted. Appetite is increased by pleasant emotions, such as sight, taste or smell, and decreased by unpleasant ones. Appetite may exist without hunger, such as a desire for dessert after eating a large beef-steak. On the other hand, hunger may exist without appetite, as illustrated by the individual who complains that he is terribly hungry, yet as soon as he has a few mouthfuls of food, can eat no more. There may, therefore, exist several combinations of hunger and appetite, but the child who has poor appetite presents the most difficult problem. To him the memory of meals blocks both appetite and hunger. We see, thus, that appetite and hunger differ, but are related.

Tampering with the hunger-appetite reflex is dangerous and is often the cause of a permanent anorexia. This reflex may be interfered with in the stomach, where it originates (e. g., by poor mastication, eating between meals, by certain foods slow in emptying, by illness and high fever), or in the brain, where the mental factors affect the appetite alone. The result of poor appetite is to cut short the eating reflex and thus deprive the child of a pleasure which is his right. This natural eating reflex must be respected, and it has been said that there is as much logic in attempting to regulate it as there would be in regulating the reflex which controls our oxygen intake. As Brenneman has put it, "The child has rebelled against over-regulation with no regard for his own desires. He has either refused to eat, or has vomited, or has dawdled over his food."

Let us consider for a moment the psychologic factors which may influence appetite. Most mothers will come with the statement that the child has no appetite because it is "nervous". This may be so, but perhaps the child is "nervous" because it has no appetite, and by being deprived of its natural pleasure, by passing through three battles a day with its mother, by being surrounded at meals with an attitude bordering on hysteria, may it not have lost that nervous stability necessary for complete health? Certainly "nervousness" (so called) and lack of appetite form a vicious cycle, one continually augmenting the other.

A child's mind has certain characteristics which may influence its appetite. To again quote Brenneman: "Anorexia is a combination of negativism, conditional reflex, desire for the spot-light or sympathy or domination and a dash of atavistic cruelty." This succinct summary gives us an excellent insight into the psychogenetic factors and offers excellent suggestions as to the means for combating this condition. The child's mind, however, is not the only factor which influences its attitude toward its meals. Appetite, being psychic, is also influenced by the attendants surrounding the child. There may be too many attendants, each trying different methods, with resulting confusion. There may be different kinds of people attending the meals whose attitudes toward the child and its refusal to eat may

vary and conflict. The proper technic must be outlined and adhered to. To properly manage a case of anorexia nervosa, the attendants must understand something of dietetics and child psychology. A little time spent in teaching them the fundamentals of the latter is effort well repaid.

The last, and perhaps most important, factor which influences the child's attitude toward meals is the technic of the meal itself. Less frequently does the fault lie with the selection of food than with the method of feeding. Meal-time should be a happy time. There should be cultivated a "Come on, let's eat" attitude. I believe one of the reasons anorexia is so infrequent in institutions is because meal-time is regarded by the children as the big time of the day. The attendants should maintain a detached attitude, not hovering or appearing over-anxious. Certainly, story-telling to induce the child to eat is not advisable, although general pleasant conversation (not about food) is helpful. Quarrels at meals or clashes of wills should be avoided. I would not insist that the child leave the table to wash its hands, and if food is accidentally spilled on the table cloth, it might better be passed off lightly. The helpings of food should be individual and moderate. A child enjoys the sensation of cleaning up its plate, and when confronted with a helping which is manifestly more than he can consume, he will often give up in despair without even trying. Too many courses should also be avoided, and the food is best served as a plate-lunch.

The question most frequently asked is, "How shall I act if my child refuses his food?" The best method of handling this is to terminate the meal without comment. To take the food away, and tell the child it is naughty or will be punished, vitiates the entire effect of what we are trying to accomplish. The attendant must appear indifferent. I always advise mothers to administer large doses of "purposeful neglect". No one continues to punch a feather-pillow. It requires resistance to continue a fight. Therefore, avoid argument. Silence and indifference on the part of the parents soon destroy part of the zest of not eating. A reasonable time should be allowed for the meal (½ hour is usually sufficient), and after this period has elapsed, the meal should be terminated. With older children, who have a habit of dawdling over meals, the alarm-clock régime is useful. This consists in bringing in the meal, setting it before the child, and then setting an alarm clock in the room to ring in ½ hour. The child is left to feed itself, and when the alarm rings, the mother returns and removes the dishes without comment, regardless of whether or not the child has finished its meal. This routine is repeated with each meal, and the child quickly learns to eat all it intends or wants to eat before the alarm rings.

Finally, the parents should set a good example, and should avoid disciplinary measures. The meal should not be the time of trial and judgment, when mother relates to daddy all the trouble she has had with Johnny that day. No child can look forward with enthusiasm to such a repast.

The foregoing, of course, is only a general technic, and will not apply to all cases. Each child must be studied individually and the proper technic outlined.

The physiologic factors which influence appetite are also important, but as everyone is familiar with them, it is not my purpose to discuss them. I shall mention them only briefly. Hunger and appetite may be influenced by foods rich in fats, which are slow in passing out of the stomach; by intervals between meals, which should be sufficiently long; by large amounts of starches and sweets which may cloy the appetite; by proteins and meat extractives, which have a stimulating effect; and by fresh air and exercise, which help consume calories. The consideration of these factors may tend to stimulate an existing appetite. However, where no appetite is present, or where there is an actual aversion to food, we of necessity must think of the much-abused and undoubtedly over-rated vitamins, so-called tonics, the presence or absence of over-feeding, constipation, food idiosyncracies, and even the ever-present teething.

As with most other medical conditions, prevention of anorexia is easier and more important than treatment of an established case. The first step in prophylaxis is propaganda. Nurses, teachers and parents must be educated

in the fundamentals of child psychology. It is the doctor's job to explain to the mother why the child eats or refuses to eat, and to preach to her the gospel of never forcing food, and that it is better to have a thin, happy baby, than a fat, discontented one. Prevention should start during the first few days of life, and with full-term babies, it is better to give nothing but water until the milk comes in, so that hunger may be allowed to develop. The baby should be taught early to take its food from a bottle or spoon, and weaning difficulties avoided by a gradual transition. If the bottle is refused it is better to starve the baby and start with a low ration. Over-feeding should positively be avoided and a formula never increased unless the baby is draining the bottle. Treatment of the first attack of anorexia is most important and should not be passed over lightly. While this may be only temporary, it is the best time to explain to the mother how it should be handled to avoid trouble. The baby should never be forced to eat, food should be temporarily withdrawn, a lower ration then permitted and gradually built up as appetite returns.

In older children, prevention becomes more psychologic. Here it is doubly important that the parents read something on child psychology. "Caloric" diets should be discarded and appetite be permitted to act as the guide. I never prescribe the quantities of food that should be given to a child over one year of age, and always emphasize to the mother that the diet list I have given her does not include all the food her child must have, but only those things he may have if his appetite warrants it. It is not so much what is fed to him as how it is fed to him that determines whether a child will become a feeding problem, and for this reason, the proper technic of meals should be observed, as already described. We must again remember that appetite is the most reliable guide to the needs of physically normal children, and fortunately this includes the majority of poor eaters.

It is most difficult to describe the treatment of an established case of anorexia. As with all psychologic conditions, different psychologic factors may produce the same end-result in different individuals, and treatment must necessarily be directed against the offending factor. Most failures are due to the doctor's inability to "sell" the idea to the parent that appetite in itself is a goal worth striving for, and thus failure is often reported after a trial of only a day or two.

In infants, who eat mainly because of hunger, treatment is comparatively simple. It may be necessary only to remove some offending food, or if baby is being overfed, to remove the cream or reduce the food in other ways. Reduction of food is the keynote. Starvation, followed by a low ration gradually increased, will normally accomplish the desired result. Of course, physical causes for the anorexia must first be excluded, but if absent, the psychologic aversion must be treated in order not to perpetuate the trouble.

In older children, it is necessary to first determine the cause of the anorexia, before it can be successfully treated. The child should be examined to exclude physical causes, such as infections, anemia, organic disease, or malignancy. Hygienic causes and dietary causes, as before mentioned, must also be excluded. If none of these is operative, a careful history should be taken to understand the possible psychologic causes. These may exist in the child (such as negativism, desire for sympathy, attention, or domination, interest in other things, desire to go out and play, imitativeness, conditioned reflex), or in the attendants (such as multiplicity of methods, too many attendants, wrong psychologic methods, lack of purpose, haphazard methods), or in the technic of the meal (such as forced feeding, oversolicitous attitude, too much discipline, emotional strain at the table or before eating, story-telling for reward, unpleasant surroundings, too much time allowed at meals).

As can be readily seen, with such a diversified list of causes, no routine treatment can be outlined and only general principles can be stated. However, if we can educate parents with time and patience, success is usually obtained. Food intake and gain in weight must be forgotten. Sometimes it is even necessary to remove the child from the presence of the parents and put a nurse in charge to carry out the program outlined. This is especially necessary when the parents have neither the will-

power nor strength of character to carry out the temporary starvation and purposeful neglect which is often necessary.

Above all, this problem requires thought. It cannot be disposed of by writing a prescription or formulation of a "wise-crack". Expenditure of money for medicines is much easier than expenditure of a little thought on our children's problems, but in good times or bad the latter is an investment that yields marvelous dividends.

DISCUSSION

Dr. Arthur Heyman (Newark): I am glad that Dr. Levinsohn insists on the psychologic being so much more important than physical influences in the causation of anorexia. Perhaps a more general understanding of this fact will prevent the removal of many tonsils and adenoids that had no bearing on the anorexia of their owners. Of course, for an all too short period after tonsillectomy, many children eat better, but obviously this improvement is due solely to the temporary starvation necessitated by the painful post-operative throat.

It is a novel observation that frequently height-weight tables are a cause of anorexia instead of a guide to improvement. It has been shown that, beginning with the wide promulgation of data collected in the World War Draft Board Examinations, the laity has been intensely interested in charts, and perhaps we too have been unduly influenced. The desire of parents to fit their children to the theoretic requirements of a chart has frequently led them into the pitfalls of illogical stuffing with foods, with consequent induction of anorexia.

Our sphere of greatest activity should be in prevention of anorexia, which means, mostly, education of parents and attendants.

In conclusion, I would like to take a firm stand against the feeding of milk between meals to the undernourished anorexia child. As far back as 1923, it was conclusively shown that between-meals administration of orange juice, with far less calories than milk, produced much better gains in weight.

Dr. Samuel Emlen Stokes (Moorestown): There is just one point that was not mentioned by Dr. Levinsohn and which I think properly enters into a consideration of this subject. Of course, irritability, nervousness, and excitement are causes of anorexia, but at the bottom of all this we find *fatigue*. I think it is important that those of us who are advising mothers should take up the question of fatigue.

Dr. F. C. Johnson (New Brunswick): I would like to suggest the use of an important little book, which might well have been the forerunner of this paper. It was written by Charles A. Aldrich and is called "Cultivating the Child's Appetite". You can hand it out to mothers and discuss it with them. With intelligent reading of that book and helpful coöperation from both parents, one can often accomplish more than by sitting down for hours and talking about the condition, with the child sitting restlessly on the mother's knee while you are trying to tell her that a peaceful attitude is one of the most important factors.

Dr. I. Zweigel (East Orange): Dr. Levinsohn's paper is instructive and elucidating. One of the causes of anorexia in children might be considered more in detail—the endocrine etiology. Often we see mal-nourished, emaciated, and apparently under-weight children who, on physical examination, show no organic or physical cause for the anorexia. We treat these children symptomatically and find them gradually gaining and approaching normalcy as they assume sexual maturity. It is my opinion that the question of physical activity or non-activity, here, is not of prime importance. Mature sexual glands are important factors in determining the physical development of children. With proper physical progress, anorexia, as a problem, usually disappears.

Dr. Levinsohn (closing): Dr. Zweigel mentioned the importance of dyscrasia in the consideration of anorexia. This, of course, would be an organic cause which should be investigated. As a matter of fact, Topper at Mt. Sinai reported last year on the effect of thyroid therapy on under-developed children. It was found in a certain number of these children whose basal metabolic rate was normal that thyroid produced an increase in height and weight. Large doses of thyroid did not increase the B. M. R. of these children, whereas the fat, obese type of child with a subnormal basal rate showed an acceleration when thyroid was given. Glandular causes no doubt exist and glandular deficiency in the child who is not thriving should be investigated.

The matter of fatigue is particularly important, especially if we consider that most of these children who will not eat are of the very active, so-called nervous type who are anxious to play and are not interested in food. These children often play too hard and are too tired to eat. Very frequently if the play is restricted or a rest period is enforced before meals, these children will eat a great deal better.

Dr. Johnson spoke of Dr. Aldrich's book. I can highly recommend it. I think Dr. Johnson must have recognized certain lines in my paper as coming from that book. He refers to interfering with the hunger reflex which controls the intake of food being as logical as interfering with the respiratory reflex which controls the oxygen intake. Aldrich expresses himself so clearly that it is a very useful book for the mother, if she has the capacity to read and understand it.

CARCINOMA OF THE THYROID, WITH SKELETAL METASTASES

W. W. Maver, M.D.,
Jersey City, N. J.

In examining bones showing definite evidence of metastatic processes, we are inclined to think of primary foci in the breast and uterus—or in the prostate of a male.

A review of the literature on this subject brings to our attention the frequency of metastatic bone lesions subsequent to a malignant process in the thyroid gland, and furnishes enough evidence that this complication

is sufficiently encountered to entitle it to a definite place in bone metastasis.

An article by Dr. Isaac Levin in the American Journal of Pathology (1930) makes the following statement: "In bone metastases in the female, think of the breast and the thyroid gland and, in the male, think of the prostate gland and the thyroid." Whether or not this is over-emphasis is open to question, but that the thyroid gland is frequently the site of the primary lesion is certainly true, and it is also noteworthy that the growth may involve and metastasize without any definite clinical evidence of its presence.

The experience of writers differs as to the order of frequency of involvement of the bones of the skeleton. Dr. David Eisen, writing in the American Journal of Medical Science (1925) finds skeletal metastases in the order—skull, inferior maxilla, sternum, long bones and pelvis. A series of 238 cases of thyroid malignancies published by Oscar Ehrhardt, of Germany, shows the occurrence of bone metastases as skull, vertebrae, pelvis, sternum and femur; while Rosenthal and Wells, of Melbourne, Australia, give the order of frequency as skull, sternum, ribs, spine, humerus, femur and pelvis.

Averaging a number of articles in which the frequency of skeletal metastases has been quoted, we find that the order is usually skull, vertebrae, long bones and pelvis.

Malignant growth of the thyroid gland simulates breast and prostatic carcinoma in its predilection for metastasis to bone. Clinically, it is well recognized that an inconspicuous or "latent" thyroid growth may produce extensive remote metastasis, the origin of which may long remain obscure.

Case 1. Mrs. S., aged 47, was admitted to the hospital Dec. 26, 1929, under service of Dr. Jonas Unger. She was a well-developed and well-nourished Italian female, from whom a history was difficult to obtain because of her inability to speak the language.

A routine examination of the cervical region showed an arterial pulsation more pronounced than normal, and a palpable thyroid gland, the left lobe of which was more enlarged than the right. Her chief complaint was pain on flexion in both thighs. X-ray examination at this time showed evidence of an old fracture involving the neck of the femur, that was evidently pathologic in character, and had united with some degree of deformity in the relationship of the femoral neck and shaft. A marked degree of loss of the calcium content of the bone structure was noted both in the pelvis and femur, and the cortex gave the appearance of being dissolved away from the periosteum. The zone of greatest destruction lay in the intertrochanteric portion of the femur.

The patient left the hospital for a time but to return on January 29, 1930, when the principal complaint was pain in both extremities and rapid heart action. During her stay, the hip and leg were placed in a cast, and about 1 month later she became delirious and difficult to handle, suffered delusions and believed that an attempt was being made to poison her. Her cardiac condition improved during this interval, and she was discharged from the hospital on March 17, in an ambulance, with the notation: "Cardiac condition improved; bone condition unimproved." A short time after, she entered the Hospital for Joint Diseases and a thyroidectomy was performed. The pathologic report was: Specimen consists of lobular masses of tissue, one containing a calcified nodule. Both masses firm. Since they are fixed in Zenkers, it is difficult to make out much from the gross appearance. Microscopic sections show extensive tumor necrosis and a large amount of calcified connective tissue, but there are also numerous lobules of glandular tumor; some showing epithelial cells arranged in follicles containing what appears to be colloid; while, other places, the tumor is more cellular and the epithelial cells are quite colloid. Diagnosis: Adenocarcinoma of the thyroid.

This patient died, but an autopsy was not obtained. As we review this case, it is obvious that the patient was suffering from a toxic thyroid that had already metastasized into the left femur prior to her first hospital visit.

Case 2. A male, aged 63, was admitted to the hospital under the service of Dr. Joseph A. Devlin. His past history was negative, except that he had formerly used alcohol to excess. The principal complaints were soreness

extending from the back around to the chest, especially on bending the head, and inability to walk. There was no feeling in the abdomen, and he experienced difficulty in passing his urine.

The symptoms were suggestive of a spinal cord lesion, and a neurologist called in consultation made the following notations: "About 4 years ago he began to have singing in his ears and head noises that he attributed to alcohol, so stopped using it. He then began to feel weary and restless, to have trouble with his feet and pain in his ankles, and his abdomen began to swell, but he had been able to work up to about 1 year ago.

Physical examination: Well-built and nourished, of fair musculature. Heart increased; no murmurs; regular rate 80 (recumbent); blood pressure 145/90. Moderate arteriosclerosis. He did not show any mental symptoms; no intelligence defect; no impairment of memory. Not nervous or tremulous. Signs and symptoms of a spastic paraplegia, evidently due to a lesion of the upper motor neurons. Lateral sclerosis.

An x-ray examination showed evidence of bone metastases in the dorsal and lumbar spine. The primary focus was not suggested, and the clinicians felt that the primary growth originated in the spinal cord. After some deliberation, and influenced by the evidence obtained following a spinal puncture, laminectomy was performed. An examination of the fragments of bone so obtained supplied information relative to the primary growth. The report of the pathologist, Dr. Schleussner, follows: "Several flat irregular fragments of bone. Microscopic section of bone shows deposits of epithelial cells in the narrow spaces. These cells are arranged in islands and strands; many arrangements closely resemble thyroid tissue. The individual epithelial cells are poorly-defined, and stain a dull, bluish-red with hematoxylin-eosin. Many nuclei are present, pale and vascular, with distinct nucleoli. No colloid seen in the acini. Diagnosis: Metastatic carcinoma, probably thyroid in origin."

The patient remained in the hospital for a few weeks and then returned to his home. It is interesting that this man was still alive about 10 days ago when we were in telephonic communication with his home.

In neither of these cases did I suspect the thyroid gland, and this citation may serve to suggest to others the possibility of the thyroid as the primary focus of skeletal metastases.

DISCUSSION

Dr. E. E. Downs (Woodbury): We recently had a case referred to our institution with a lesion in the femur which was very similar in appearance to the case shown by Dr. Maver. We suspected secondary malignancy and searched carefully for a primary tumor. It was not until the skull was x-rayed that we discovered we were dealing with an osteitis deformans. I was glad, therefore, when Dr. Baker asked if the other bones were taken. I believe that in many of our thyroid cases there is a secondary effect on the parathyroids which produces by its disturbed calcium metabolism a condition similar to osteitis fibrosa cystica. The Mayo Clinic exhibited last winter a series of films showing changes in bone, mostly osteolytic in character, which many of us would have believed from an examination of the films to be metastatic lesions. They were proved to be absolutely benign since after thyroidectomy and the relief of the thyroid toxicosis, the bones recalcified. I feel, therefore, that we cannot be too certain when we see bone lesions of this type on our films until we have found the primary tumor and even better examined a section of it under the microscope.

I was very glad Dr. Maver had the primary tumor in the first case. I am going to try to borrow the films and slides from him.

Dr. R. Pomeranz (Newark): I want to support the last statement of Dr. Downs. In a report in the Clinical Magazine of Berlin, 2 weeks ago, concerning the parathyroid condition in connection with Recklinghausen's disease, a similar case with metastasis throughout the entire body was described.

ACUTE SILICOSIS

R. Pomeranz, M.D.,
Newark, N. J.

Occupational fibrosis due to inhalation of dust containing free silica has been known for years, and the name implies a slow development of the condition. It is called "chronic silicosis" because it takes from 3 to 15 years to develop. Until 3 years ago, very few cases were reported that showed rapid development. In 1931 one case, with the microscopic findings, was reported in Germany, by Giese. Two cases were reported by MacDonald in England in 1930. Pancoast and Pendegrass reviewed their experiences with the rapid type in an

article in the Journal of Roentgenology, Oct. 1931. In a recent issue of the J. A. M. A. there was a report of 3 cases by Chapman. We had an opportunity, through the courtesy of Dr. Gluckman, to examine a series of cases of acute silicosis, arising in the pulverizing plants in New Jersey.

We call this type of silicosis "acute" because of its rapid development due to massive exposure, lasting from 3 months to 3 years, to a powder containing high free silica content. The time of exposure is relatively short as compared with chronic silicosis. The term "acute" is warranted for other reasons also, as it will be shown that the condition is much more dangerous both in the pure form of silicosis or the silico-tuberculosis.

We know that under normal physiologic conditions, the lining of the nasopharynx, and of the bronchi and bronchioli, is a very efficient dust filter, so that the air that reaches the alveoli is practically dust free. This situation changes under pathologic conditions. The efficient dust filter of the upper respiratory tract is broken down by the small dust particles which produce infectious desquamative changes of the cells forming the lining of the bronchioli, impairing their function of elimination of dust particles, and permitting a large number of such dust particles to reach the alveoli.

The size of the dust that reaches the alveoli is comparable to the size of a pathogenic bacteria. These particles are partly expectorated in the sputum. The remaining larger part is phagocytised. The leukocytes carrying the dust particles—called dust cells—wander through the lymphatics to the glands, and some reach the tracheobronchial glands. Many of the dust cells die on the way to the glands, poisoned by the free silica. The over-loaded lymphatic vessels become blocked, and burst, so that the dust cells and free silica get into the perilymphatic spaces. Small arteries accompany the lymphatic vessels. This explains how the silica gets into the peri-adventitial tissue of the small arteries. The dust particles deposited there cause reactive fibroblastic changes, with lymphocytic infiltration, forming early stages of dust granulomas. As a rule, these are situated around small arteries. They grow by additional fibroblastic tissue-formation, followed by regressive changes. The central artery around which the dust granuloma—later called silicotic nodule—forms undergoes constantly further regressive changes. One nodule may fuse with a neighboring one, forming larger nodules. A large amount of dust particles can be found in the nodules.

The formation of the pathologic fibrosis, as above described, has been confirmed by experimental exposure of guinea-pigs to the same dust used in pulverizing plants. Four weeks of exposure only produced in the lungs large pneumonic foci of fibroblastic productive infiltration. The findings after an intravenous injection of silica dust were the same. This partly explains the severity of the poisoning effect of free silica on the pulmonary tissues. Twelve weeks of exposure produced a general interstitial fibrosis of the pulmonary structures, with early dust granulomas. These, as a rule, were situated around the arteries. Dust particles could be seen in the interstitial septa. Half a year after a three months exposure, all the above-described changes of interstitial fibrosis had advanced more or less evenly over all the lobes of the lungs. This explains the progressiveness of the condition. It is self-evident that only a part of the inhaled silica dust can be eliminated, the bulk of it enters the alveoli, is phagocytised, remains in the lungs and glands, and continues its toxic effect on the tissues.

A pulverizing plant in New Jersey employed a number of white and colored men in the manufacture of fine silica powder, using large machine-driven mills for grinding the stones. The powder was of such a fine quality that it was used in the manufacture of cleansing and tooth pastes. Some particles were smaller than a micron. In this plant men worked about 10 hours daily. Their duties included watching the machines and frequent cleaning of them. To facilitate cleaning, the walls of the mills were tapped to shake off any dust that may have been deposited on them. Some of the employees worked in a "bagging room", loading and unloading bags filled with the manufactured product. The fine silica dust was introduced through the opening of the mill and the pipes into the free spaces of the large hall where the men were working. The ventilation

system was extremely poor. The men, as a rule, used no protective masks while at work.

Two samples of powder were submitted for examination—"coarse" powder, which showed particles 2-20 microns in size; and a "fine" powder, the bulk of which showed particles 1-¼ micron in size. A chemical examination was performed by the Clinical Laboratory of Mr. Asen. It showed free silica, as SiO_2, in both samples, 98.6%; soluble silicates, 0.5%. The rest was comprised of calcium and magnesium salts, with some iron and aluminum oxides.

From the series of cases examined, we wish to report 5 with autoptic control.

Subjective symptoms common to all 5 patients were: shortness of breath, pronounced on exertion, loss of weight, non-productive cough, occasional pains in the chest, transient in nature, and occasional night sweats and rising temperature.

Common clinical findings were (Dr. Gluckman): restricted chest expansion, dulness over both hilar regions, rough breathing with occasional râles over both central lung-fields.

Case 1. G. V., male, colored, 24 years old, worked in the plant over 1½ years. X-rayed May 8, 1929. Died January 4, 1930.

X-ray findings: Uniform fibrous infiltration of both upper lobes and of right base mesially. Both hilums enlarged, increased in density, and partly fused with the described fibrous infiltration of the lungs. Apices and bases fairly free, with no evidence of focal infiltration suggestive of active tuberculosis.

Autopsy by Dr. Martland: Left lung: Large, well hardened by embalming. Over posterior surface of lower lobe, small amount of fresh fibrin. Lung is of peculiar light brown-gray color, on cut section, exuding a small amount of frothy, but not blood-stained fluid on pressure. Hilus nodes are large, some being 3 c.m. in size, and show same brown color on section. No tuberculosis of lung, no primary affection, no reinfection. On close inspection of cut surface with hand glass, there is marked fibrosis of hilus, with grayish streaks radiating into lung parenchyma. No noticeable anthracosis. Right lung same as left.

Microscopic findings: General interstitial and nodular fibrosis, with accumulation of dust particles, smaller than a micron in size, in the nodules. Most of the single nodules are fused with neighboring ones to larger units. Fibrous nodules show different stages of regressive changes and are situated, as a rule, around a small artery. Small lymphocytic infiltration can be seen around nodules and bronchi. No anthracotic pigment in septa. The parts of lungs that show no fibrosis show emphysema.

Case 2. J. M., male, colored, 20 years old, worked in plant 14 months. X-rayed August 17, 1929. Died May 5, 1930.

X-ray findings: Marked enlargement of left hilum shadow, with increased markings radiating centrally. Both hilums increased in density. Otherwise both lung-fields are clear. Both diaphragms show fair function.

Autopsy by Dr. Martland: Left lung: Carnified adhesions over all pleural cavities. Large cavities in left upper lobe. Hilus nodes enlarged and of mottled blue-gray color. Left upper lobe, almost entirely destroyed by 6 in. cavity, composed of gray eroded masses of lung tissue in which dissection of bronchial tree and pulmonary vessels, many of which are thrombosed, can be seen. Upper part of lower lobe shows numerous discrete communicating cavities, ½-1 in. in size, and gray, chronic, exudative and acinous tuberculosis.

Right lung: Whole upper lobe solid with chronic productive acinous tuberculosis and with small cavity formation. Middle lobe same. Lower lobe shows discrete areas of chronic tuberculosis.

Cause of death: Pulmonary tuberculosis silicosis.

Microscopic findings: Characteristic of caseating tuberculosis. Hilus nodes are packed with silica dust particles.

Comment on Case 2. This case shows the result of a reactivated latent tuberculosis due to exposure to dust containing high silica content. When x-rayed 8 months prior to death, the active process was just beginning in left upper lobe and glands of left hilum. The course of the tuberculosis was rapid.

Case 3. J. M., male, colored, 52 years old, worked in plant 3 years. X-rayed August 16, 1929. Died early in 1930.

Specimen of the lungs sent to Dr. Martland for histologic examination.

X-ray findings: Uniform general fibrous infiltration of lung-fields, most pronounced at left base. Hilums enlarged and increased in density. Pulmonary markings dense, showing nodular infiltration, forming a network. Diaphragms show restricted respiratory movement. Apices more or less free. Bases show increased aeration.

Microscopic findings: Fibrosis similar to above described Case 1, with anthracotic infiltration of some of the interstitial septa. No evidence of tuberculosis.

Case 4. J. McC., male, colored, 27 years old, worked in plant 2 years. X-rayed January 15, 1930. Died May 14, 1930.

X-ray findings: General interstitial fibrosis of both lungs, more pronounced on right side. Both hilums increased in density. Apices and bases free.

Microscopic findings: Lungs delivered to Dr. Martland. Nodular and interstitial fibrosis same as in Case 1 and 3.

Case 5. G. McR., male, colored, 50 years old, worked in plant 2 years. X-rayed November 13, 1929. Died in 1930. Lung sent to Dr. Martland.

X-ray findings: Cloudiness of upper third of right lung-field, extending toward right hilum, which is fused with it. Increased fibrous markings extending toward right base and in left central lung-field. Left diaphragm elevated. Both diaphragms show restricted respiratory movements. Heart, aortic.

Microscopic findings: Fibrous tuberculosis of right upper lobe, with silicotic nodular and interstitial fibrosis of the other lobes.

Conclusions

(1) X-ray and microscopic findings in 5 cases have been presented from a large series of acutely developed silicosis patients.

(2) The dust silica particles below one micron in size were deposited in the interstitial lung tissue and in the glands.

(3) The experiments show the extent of toxic action of silica, especially on lung tissue. They also show the progressiveness of the fibrosis.

(4) That the fibrosis is progressive and irreparable can be seen from the serial roentgenograms of the living men after they gave up their occupation.

(5) The fibrosis is due to deposit of minute particles of free silica in the interstitial tissue of the lungs. It could be considered a defense reaction of the organ to the toxic (chemical and colloidal) effect on the cells.

(6) A case of tuberculosis acutely reactivated after exposure to silica dust has been shown.

It is evident that the problem is to prevent the fine particles (one micron and less) from entering the lungs of employees. This can be achieved by:

(1) Mechanical improvements, such as masks, ventilation, etc.

(2) Shortening the hours of exposure of the employee—4-hour shift, for instance; limit the period of work to 6 months or introduce frequent change of work for the individual employee in one plant.

(3) Preëmployment thorough examination of the applicants, with x-ray of chest. Any applicant showing signs of latent or active tuberculosis should not be employed in this industry.

(4) Periodic health examination of every employee, including x-ray, every 3 months.

(5) Every case of established silicosis should be compensable by law. The extent of compensation should depend on extent of involvement. A great deal of work is still to be done by medical men in establishing a proper classification of silicotic involvement in relation to compensation.

(6) No man who shows signs of even a beginning silicosis should be allowed to continue this work.

(7) If all the mechanical and medical improvements do not succeed in diminishing the dangers of the exposure, the manufacture of this fine dust should be discontinued.

In concluding, I wish to express my sincere gratitude to Dr. Martland and his laboratory staff for their generous help, without which proper presentation of these cases would have been impossible.

DISCUSSION

Dr. Harrison S. Martland (Newark): First, I might call attention, just in résumé, to the fact that we must realize this is a comparatively young industry, in which sand and silica are used in finer

form than they have been used in the past. It is a large industry, important in the cleaning of buildings, scouring articles that require very fine silica dust. So that here is evidence that there is a new industrial form of silicosis which will affect man in much shorter time, on account of the smallness of the particles, than seen in the past in the case of granite cutters or rock drillers.

I think the assumption that you could classify such an occupational disease as an acute or subacute form of silicosis, to distinguish it from the common chronic forms that took years to develop, is good. The next thing that occurs to me is that whenever an occupational disease is discovered or recognized, then the compensation courts are filled with borderline cases, where anyone who ever walked through the quartz factory has silicosis. It is for you men to determine, as radiologists and roentgenologists, where you can absolutely diagnose borderline cases and determine how much they are affected.

That brings to mind the diagnosis of pulmonary syphilis, which I have always regarded as a diagnosis made by roentgenologists but seldom proved at autopsy. There are all sorts of hilum fibroses that are easily confused with syphilis. It is difficult to determine at autopsy, by careful microscopic work, whether there is such a nebulous entity. In some of these cases, even at autopsy, it is difficult to say that it is silicosis, especially in cases which are obscured by enormous exudative tuberculosis or greater cavities. You have to go over the lungs very carefully to prove that that is superimposed or activated by silica.

In this plant there were some patients with pure silicosis, not tuberculosis; they were negroes who hadn't lived in cities and had little anthracosis. The first case reported is pure silicosis. The lung was a pinkish-red, dirty gray color and microscopically hardly any opening at all. That is an excellent example of silicosis. Of course, where the silicosis is complicated by old anthracosis, it is sometimes difficult to distinguish minute anthracotic material histologically.

When we set up our apparatus in the laboratory —this cage with a blower and sand and rotary pump—I never expected to produce experimental silicosis in such a short time, with 2 months' exposure. Garner and the South African investigators took a long time to produce it in animals. I think this is one of the earliest experimental works on the production of silicosis.

Chairman Baker: I would like to ask what the actual cause of death was? How did they die?

Dr. Martland: That is important. I intended to tell that. In the Vincent case, the lung looked almost like a miliary tuberculosis—thousands of little tubercles all over the lung. The intervening tissue was apparently perfectly good. How did that man die? There was no tuberculosis complicating the case; it was pure silicosis. A great deal of the intervening tissue looked grossly all right. We can only explain it by the fact that when you put all those nodules together and see the proportion to the healthy lung, you find enough to interfere with the vital capacity of the lung to a great extent. It is the same as in the interstitial pneumonias that followed the influenza epidemic. There is a great interference in vital capacity, with production of cyanosis and dyspnea, and a terminal cold or bronchitis on top of that will cause death. Of course, the other is complicated with tuberculosis. They die from tuberculosis more than they do from silicosis. Another thing is the character of inflammation. All the handling of pigments and foreign bodies in the lung is purely a lymphatic affair.

Pathologically, we have been taught for years that the alveoli are lined with alveolar epithelium, but that is doubted by some. Some say the bronchial epithelium goes directly and stops, that there is a mesiothelial lining produced by histocytes and there is no such thing as an epithelium lining the alveoli. If that is so, it is much easier to explain the entrance of all foreign pigments, silica, tubercles and such, into the interstitial tissues of the lung, where they produce fibrosis along the perivascular lining. It will be recalled that in the pandemic pneumonias during the war, the interstitial pneumonia that produced the same nodular miliary effect over the lungs caused considerable fibrosis afterward, in the lungs, if the patient survived. That was an interstitial pneumonia. Pandemic pneumonia is followed by permanent changes in the lung which may give confusing x-ray pictures years afterward. A lobar pneumonia clears up after the crisis, and produces no intense interstitial inflammation. Two weeks afterward, if you examine the lungs, you cannot find evidence of pneumonia. That is the difference between lobar and interstitial forms of pneumonia.

Dr. M. James Fine (Newark): I am glad Dr. Pomeranz and Dr. Martland have brought out the question of tuberculosis and silicosis at this discussion. We have in the Tuberculosis Service at the Newark City Hospital quite a few persons who were admitted as miliary tuberculosis patients, and the only way to make a definite diagnosis of silicosis is by x-ray and physical signs. The physical signs and symptoms that arise in silicosis differ from those of pulmonary tuberculosis. We have a great deal of dyspnea and few physical signs in the chest of the silicotic patient. The x-ray shows a great deal more than the physical signs. The proportion of dyspnea and movement of the chest is out of proportion to the signs. There are few râles especially crepitant, as you usually find in tuberculosis.

Chairman Baker: Is this in the chronic case?

Dr. Fine: In the chronic as well as in acute stage of silicosis, you find the physical signs are just as negligible, but the x-ray and the symptoms are rather exaggerated, which you don't find in tuberculosis. Regarding exposure to silica dust, Dr. Lanza, Dr. Goldberg and Dr. Emerson of New York, have made a study of the grinders, the rock grinders and drillers in the subways in New York, and they found that there, silica dust is found in the chest after 25 years of such work without any detrimental effect on the patient.

Dr. Pomeranz said that silica dust has some effect on the parenchyma of the lung and causes destruction of the cell. I wish Dr. Martland would explain what effect silica has on the cells and how it causes death in a patient with silicosis.

Dr. Pomeranz further mentioned the importance of finding out before a worker goes to work in a silica plant whether he has or has had tuberculosis. I think it is vitally important to find out whether the patient has or has had any pulmonary condition such as pleurisy, pneumonia, bronchitis or bronchiectasis, because the danger of silicosis is greater than otherwise when coming in contact with silica dust.

Dr. Pomeranz suggested that an x-ray examination of every patient working in a silica plant should be made. To do this would be expensive. I think it would be more advisable to have the medical

man who does the work in the silica plant acquaint himself with a fluoroscope and be able to recognize early findings of the chest. A fluoroscope installed in the plant would serve the purpose. I have enjoyed the paper immensely and have learned a great deal from the discussion.

Dr. E. Reissman (Newark): Silicosis is rapidly becoming a compensable disease and I think it would be advisable to study it from that angle. I hope it is not going to take its place along with the sacro-iliac joint that we hear so much about. Of course, we have no quarrel with silicosis that is aggravated or with the intermediate stage, but I am particularly interested in the early stage, the one that Dr. Pomeranz showed here this morning, and of which he said that in a man who worked in the plant 8 months, all that was seen at first was a thickening of the hilus shadow. It is possible that this would develop into acute silicosis, but if such a workman came before the Labor Department for compensation on the plea that he had silicosis and submitted evidence of that type (namely, fibrosis and thickening of the hilus), I think we would be stretching the point to say it was silicosis. There is where the danger lies. We all know that silicosis, if it becomes acute or aggravated after a term of years, and has superimposed upon it a tuberculosis, is a terminally fatal disease. But when we have an ordinary presentation such as the doctor showed us and we presume to go to court and say that this man, having worked in a silica plant, is now a possible subject for fatal termination, I think we are going further than is called for. All of us who live where dust is prevalent are silicotic. Most of us, if we had our lungs examined after autopsy, would be found to have a considerable amount of deposit and fibrotic changes in the lungs. Before we can make a roentgenologic diagnosis—and there is no other way we can make it in the early stages—we should be obliged to see the silicotic nodule. There is no use talking about a thickening of the hilum shadow, bronchial thickening, or a bronchiestasis. That does not mean silicosis, no matter how long the man has worked in a silica plant. Dr. Pancoast made that very clear. He has made a greater examination and a more thorough study of silicosis than any man in our line of work. He has studied thousands of cases in pictures and in individuals, and he has definitely come to the conclusion that silicosis in its secondary or later stages is a serious involvement, but should in no sense be considered a compensable disease unless we see nodular formation. I agree with that. From the point of view of compensation. I don't think we should saddle on any company or any industry such primitive measures.

Dr. Martland spoke of the guinea-pig blower. We all know that guinea-pigs are very susceptible to lung involvement. We use them for tests in lung cases and it doesn't surprise me if a guinea-pig, put in a case, with silica dust blown against it, develops some sort of silicosis rapidly.

At the outset, we want to say silicosis is a fibrosis, and as such is a protective measure against all superimposed conditions; but who knows who is going to have tuberculosis? Who knows whether a patient with an aggravated silicosis, and who is susceptible, may not have a tuberculosis engrafted on it, if he inhales tuberculosis germs? So, therefore, Dr. Pomeranz suggests we should do away with the industry. If you can do that, you might just as well do away with the iron worker who works on the twenty-fifth floor of a building, for he may fall down. Occupational hazards will always exist.

I say in conclusion, I have no quarrel with the dangerous type of lung involvement due to silica inhalation, but what I want to do now is to sound a warning against designating the early type as silicosis where we have no other symptom than a man's well-coached story and a thickening of the hilus shadow with the lung markings exaggerated. That should not be considered a lung lesion just because a man works in a silica plant.

Dr. William G. Herrman (Asbury Park): Mr. Chairman, I would like to substantiate practically everything Dr. Reissman has said so far as my personal observations are concerned. I feel that this is a problem to which roentgenologists in New Jersey should give considerable thought. We should help to clarify the situation if possible, because it is an economic one. These cases are going to appear more or less in our courts, if the industry continues. If we can determine just what are presumptive signs and just what are positive signs, so that we should all have clearly the same idea, then we shall have accomplished something. The problem is like the question of childhood tuberculosis. Just what are the x-ray findings in childhood tuberculosis? There are certainly very definite and positive findings. There are some presumptive findings and then you are through. Because the child is a contact case and has a positive Mantoux does not mean that there are x-ray findings in its chest. You will find many men, even tubeculosis experts, who will see in a given run of cases anywhere from 90 to 97% positive x-ray findings in the chest. I think they are reading their clinical findings and their expectation of a large percentage into their x-ray findings. I am inclined to believe this silicosis proposition is much the same.

It casts discredit on roentgenology when two men of equal standing get up in court, and one says that there are positive evidences of first or early stage silicosis in an x-ray, while the other says there is no evidence whatsoever. We can determine in a given case whether there is definite x-ray evidence. There we should stop.

If you take presumptive evidence or history and read it into the x-ray film, it is going to carry us backward. Many in this room will remember the days when there were a great many men seeing tuberculosis in every single x-ray of the chest.

So far as fluoroscopic examination is concerned, a copy of the State Journal sometime this past year carried a pamphlet advising that everyone interested in tuberculosis should start fluoroscoping chests. I feel that I overlook in the fluoroscopic examination of chests many early and fine signs of pathology; I overlook more of them than I see. I don't think I am any worse than the great many men who are using the fluoroscope. I think it is rather hazardous to depend, in such conditions as this, entirely on your fluoroscopic examination, and it is apt to be more misleading than helpful if roentgenograms are omitted.

I would like to ask Dr. Pomeranz a question, and if this was covered in the first part of the paper, which I did not hear, I will ask him to excuse it. I want to know whether he took up prognosis. In patients who have been exposed for a short time, we will presume that the history and the x-ray evidence is at least presumptive; we will give the benefit of the doubt to the patient and agree there is evidence of early silicosis. Suppose that man is taken entirely away from the occupation and does not run into some complicating condition such as Dr. Reissman and Dr. Martland have referred to, can he entirely recover from this condition, or is the fact that he has shown early signs of silicosis presumptive evidence that he is going to progressively decline?

Dr. William W. Maver (Jersey City): I would like to substantiate the remarks of Dr. Reissman and Dr. Herrman. It was my opportunity to examine suspects that Dr. Pomeranz also examined, and we agreed on a number and differed on a number. We, as roentgenologists, in this New Jersey group, should take a firm stand on this question, which is vital not only to the patient but to the manufacturer. It has been an expensive lesson to these men who are pulverizing sand. It has swooped down on them like a cyclone and they were unprepared to meet it. It is not a compensable disease in this State so far as I can learn, and it isn't in New York. But I believe it should be a compensable disease. When it becomes a compensable disease, then, as roentgenologists, we must take a firm stand on what roentgenologic findings constitute silicosis and what do not. We should omit fibrosis from those findings. A lung that is simply fibrotic should not be considered as silicotic, regardless of how long the man has worked at that industry. I have followed these cases into court. I have seen men awarded substantial verdicts who furnished no other evidence on the x-ray film than pure fibrosis without mottling, without fibrous nodule formation. Roentgenologists should forget fibrosis, should look for the fibrous nodule formation, watch the patient over a period of time and, if it has a tendency to progress, then put him down as a probable silicotic.

Dr. Saul M. Rubinow (Newark): I am more concerned with the public aspect of acute silicosis. A series of cases was presented to us in which irreparable damage has been caused to the health of workmen engaged in a new industrial process. This new process uses for commercial purposes a very fine dust, exceedingly harmful to the lungs. From the point of view of preventive medicine and the generally accepted slogan "Safety First", one would think that no industrial process should be permitted unless it is reasonably safe to the health of men occupied in it. No other attitude can be taken by organized medicine.

Dr. R. Pomeranz (Closing): I am glad this subject has aroused so much discussion. It needs it.

I can't add anything to Dr. Martland's remarks.

Dr. Fine has said that preëmployment examination should be done by fluoroscope. With Dr. Herrman, I doubt that the fluoroscope alone is sufficient.

I want to stress the point that we have discussed here only those patients who were exposed in these 2 particular plants which produce the fine dust in question. We are not speaking about steel workers or any other workers. I don't believe we have fibrotic changes in our lungs. We have shown that the quantity of silica in the specimens of pathologic lungs is 3 or 4 times as great as in the normal lung.

I was not speaking here from the viewpoint of compensation. I was interested purely in the pathogenesis of fibrosis in the lungs, due to fine particles of silica to which the workers were exposed for a relatively short time, how the dust got there, and what it did when it got into the lungs. We know that the dust stays in the lungs, that it cannot be removed, and that the fibrosis is a defense reaction of the organ.

As to the points stressed by Dr. Herrman, Dr. Maver, and Dr. Reismann, that we should work up the definite signs of early Roentgen diagnosis of this fibrosis; this demands coöperation between all men who have had experience with these patients, particularly between the medical man and those experienced in compensation. The question is not yet solved and needs further study.

Dr. Herrman asked about prognosis. Only one of the patients shown here was x-rayed later, about a year or year and a half. The case was far advanced primarily, and the later examination showed the fibrosis still further progressed, in spite of the fact that the patient has given up his occupation. If the diagnosis of silicosis is established and there are silicotic nodules present, we can say that the progress will be steady. Until then, we have no right to say anything because we have no evidence.

It would be helpful if all the men in this State would coöperate in establishing definite Roentgen signs of silicosis. I do not believe that those who have only slight signs should be compensated. Thank you.

THE MYOCARDIUM FOLLOWING ACUTE INFECTIONS*

Clarence L. Andrews, M.D., F.A.C.P.,
Atlantic City, N. J.

The world is apparently more concerned today about heart disease than any other malady. The increasing number of cardiac deaths, and the bold headlines in news-papers—stating that Mr. So-and-So, a supposedly healthy, middle-aged individual, suddenly dropped dead, have struck terror into the minds of laymen. I have nothing startling or unusual to say this evening concerning cardiac deaths, but I have been making some "out-post" observations on heart conditions following acute infections, which I thought might interest you.

When we consider the possible causes of heart disease, we think naturally of 3 outstanding groups: (1) the group in which inherent causes operate, i. e., the individual comes into life with a cardiovascular system that is below standard and is by reason of that fact more vulnerable to disease than it should be; (2) the infectious group springing from acute rheumatic fever, syphilis, scarlet fever, pneumonia, diphtheria and tonsillitis; and (3) the great social or economic group, where the cause is our American type of living and its perpetual nervous strain.

It is the infectious group which concerns us this evening. Most physicians appreciate the importance of carefully guarding patients during attacks of acute rheumatic fever, pneu-

*(Read before the Bay Ridge Medical Society, Brooklyn, N. Y., February 9, 1932.)

monia and diphtheria, and also realize the benefits that frequently follow removal of foci of infection, such as decayed teeth, diseased tonsils, infected sinuses, chronic gall-bladders, pent-up pus tubes, chronic prostates and neglected appendices; but I doubt if sufficient attention has been given to the milder types of general infection, which do not center their attack upon any particular organ. To my mind, the chief of these is grippe.

Atlantic City offers an unusual opportunity for studying and appreciating this particular fact. Patients go there from all sections of the United States and Canada. Many have letters from their family physicians setting forth their diagnosis and treatment. Here is as nearly a "cross section study" of the psychology of patient and physician as it is possible to obtain. This type of study brings out many important points, and emphasizes the value of a complete physical examination. In fact, the less obvious actual disturbances exist, the more thorough your examination must be.

When you have completed such examination, never say to your patient, "There is nothing wrong with you; forget it." In the first place he will not believe you, and secondly you are sending away from your office wonderful material for the first shylock, chiropractor, christian scientist or faker who happens to cross his path. Say to him, on the other hand, that you are happy to inform him that he has nothing organically wrong, but that he is a bit out of tune; that one does not need to possess organic disease in order not to feel well; we are not machines, but in a sense we can be compared to them; a $5000 automobile may not run properly, although all of its parts are entirely new; the mechanic adjusts a few bolts or does something to the starter and the car runs perfectly. So it is with the human body. Then give your patient some medicine and suggest that he come back to see you in a day or two. There are two reasons for this procedure: First of all, the patient needs someone to lean on and to set him right; secondly, you yourself should want the protection of knowing that your conclusions were right and that you have not done him the great injustice of stating that he has nothing wrong with him when in reality he may need your help.

It was by following this practice of repeated check-ups in dealing with so-called "perfectly well" patients, who had recently had grippe, that I was enabled to find ample clinical material for my paper on *Grippal Infections* read before the A. M. A. in Philadelphia last year. Tonight I wish to talk to you about another phase of myocardial disease, but wish to refer to that paper as a foundation upon which to build my remarks.

Medical psychology, which has always surrounded the physician in his diagnosis of disease, interests me more than the disease itself. Hence, when some hitherto unknown disturbance in body function first begins to be recognized by the medical profession, they are often uncertain whether the great ease with which they discover case after case in their respective communities is due to an actual increase in incidence, or to greater success in diagnosing an otherwise obscure malady, because they have at their command more dependable and precise methods of approach than formerly. This eternal problem has existed ever since time began, and will in all probability disturb us for many years to come. It can be found recorded in medical literature from primitive man to our present time. It has always been the new and unusual symptoms that have sharpened our diagnostic fancies. We clinicians have an innate tendency to enjoy frequent changes in types of diseases just as we welcome variations in styles of dress. Barring, perhaps, the disturbances which grow out of the industrial age in which we live, and which unquestionably require a more intricate knowledge of these industries—in the form of gases and fumes evolved, rapid changes in temperature, etc.—than the average physician is apt to have, the same fundamental principles in physical and clinical diagnosis which enabled Laennec or Osler to stand out as leading diagnosticians still hold true for each of us today.

Perhaps it is because we frequently get away from these basic principles of cause and effect and attempt to pursue shorter and newer roads to diagnosis, or actually have our diagnosis made by someone else, that we are led astray.

With this short preamble, let us next turn to

disorders of the heart and see what has happened in that particular field.

In spite of the most modern facilities for diagnostic precision, early functional and pathologic changes in the heart are the most frequently overlooked of all disturbances of the body, and many times they are not even suspected until pointed out to us by the pathologist at the autopsy table. In a series of 3683 postmortems, performed by Lock at the Boston City Hospital, 150 instances of acute pericarditis were found, and only 27 of these had been correctly diagnosed before death. Of 1750 cases of acute rheumatic fever reported by Cowan in his *Diseases of the Heart,* 933, or 53%, early showed acute endocarditis; the heart changes bore no direct relation to the severity of the arthritis, and would in all probability have been overlooked by the average physician of today. Many of the mild cases of arthritis showed severe endocarditis, whereas other severe ones presented very little evidence of heart disease. In a series of 517 autopsies performed by Professor Welch on persons who died of endocarditis, 115, or 22%, were on persons who had had pneumonia and whose heart condition passed unnoticed by the attending physician. In croupous pneumonia, both the mild and malignant forms of endocarditis may occur, yet they are seldom diagnosed before death. Even in the typhoid types of endocarditis, in which the temperature for many days remains high, the presence of a well-defined murmur, or other obvious evidences of acute cardiac disease, are seldom recognized, because the mental focus of the physician from the outset is on the high temperature.

From the foregoing one would infer that early disturbances of the heart are the most commonly overlooked of all serious body changes and that in reality we are entirely lacking in ability to pick them up. Such a conclusion is particularly justifiable concerning our ability to recognize early changes which occur within the myocardium itself, because there may not be a well-defined murmur to put us on guard. Even in acute types of endocarditis, according to Norris and Landis, the myocardium is involved as often as the endocardium, and we should be constantly on the lookout for it. In typhoid fever and diphtheria, the heart muscle is much more commonly attacked than the endocardium; yet how many times have you heard a confrère remark that the heart is in splendid condition because the pulse rate is not accelerated?

This same complacency regarding the heart prevails in the minds of many physicians regarding so-called grippe. Oh, if we could only forget such primitive and poorly sustained conclusions. Too many physicians still regard grippe as nothing more than a systemic cold, so long as the bronchial tubes are not actively involved. To them any grippe complications, other than those associated with the respiratory system, have no significance.

Now, what is the answer to these phenomenal points of view, held by physicians who are really well trained? Why do such diagnostic errors occur with persistent regularity? It may be for the following reasons:

Acute pericarditis during pneumonia is seldom diagnosed because the precardial friction rub, if heard, is almost invariably ascribed to involvement of the pneumonic process itself, and sufficient time is not taken by the examiner to ask the patient to stop breathing long enough for the heart to be listened to while the lungs are at rest.

Early acute endocarditis in rheumatic fever, and other acute infections, escape diagnosis because the rapid pulse and rise in temperature, when encountered, are explained on the grounds of general infection, and because an accurate written record of heart sounds and cardiac outlines is not made when the patient is first seen, to serve as a guide upon subsequent visits. One of the most important single steps in early heart diagnosis is to make a record of the cardiac tone, heart rhythm and pulse rate each time the patient is seen.

In a similar manner, one might ask what there is about early myocardial changes following acute infections that makes them so difficult to recognize, and why, even in cases of acute rheumatic fever, in which we know we are dealing with potential heart disease, myocardial changes are almost universally overlooked? First, they are not regularly and carefully searched for, and sometimes they do not develop definite physical signs until the dis-

ease has made considerable progress. Moreover, medical attention has for so long been focused upon valvular lesions as the most significant disturbance in cardiac disease that the importance of other types of heart changes has not taken root in our minds.

Medicine is a growing, living subject and newer means of detecting early disturbances in organs like the heart are constantly unfolding themselves to those who care to watch them.

The length of time one has been in practice may not always determine ability to diagnose disease. If a physician made a gross error in diagnosis the day he left medical school and has not taken the trouble to follow his fatal cases to the postmortem table to determine whether he was right in his diagnosis, he may be more inaccurate in his clinical judgment today than he was at the outset. Many of us are quite prone to adhere to early medical teachings because we were instructed along certain definite lines by professors and hospital chiefs who to our young minds were supermen. They taught us that only well-transmitted valvular lesions of the heart had any real significance. I still see physicians who shiver when asked to give more than 10 drops of digitalis, however apparent the need for larger doses, simply because that amount was laid down in the book on practical therapeutics which they used as a guide.

During the A. M. A. in Philadelphia in June of last year, I attempted to point out such facts as these concerning diagnosis of the heart and to show how one diagnostic dogma regarding heart-muscle efficiency had been replaced by another during the past 30 or 35 years. The 5 distinct periods of advancement in cardiac diagnosis as pointed out by me at that time were: (1) The period from the beginning of the use of auscultation until about 35 years ago, when only organic valvular lesions were regarded as indicating definite cardiac disease, and little attention was paid to hypertrophy or dilatation, except as an accepted phase in normal compensation; (2) the introduction of x-ray and fluoroscopic studies, because hearts were found that were not normal, yet did not present physical signs of organic valvular disease; (3) the advent of the electrocardiogram, because evidences of myocardial degeneration and disturbances in nerve conduction could be demonstrated in hearts free from organic valvular changes or myocardial thickening; (4) the effort-syndrome group, or neurocirculatory asthenic type of heart, encountered during the World War. This group was puzzling because no previously known methods of detecting heart disease revealed any cardiac deficiency. It is now accepted as a distinct group. (5) The announcement by Christian, of Boston, that any heart which began to enlarge from whatever cause was no longer normal, and that, although clinicians in general accepted cardiac hypertrophy as the usual physiologic step in normal compensation, it was in reality frank evidence of beginning myocardial retrogression.

To these 5 consecutive groups or evolutionary phases of cardiac diagnosis, I added another type of myocardial weakness, or heart-muscle disturbance, which apparently had not been generally recognized before, and which occurred in patients who had passed through mild attacks of grippe without severe bronchitis or pneumonia, who had not belonged in the category of hypotention or hypertention prior to their illness, and who were not beyond 50, an age when myocardial changes might have occurred more easily. This group, reported by me, then, was taken from a list of patients whose chief complaint was great physical weakness following brief attacks of grippe, yet, who were pronounced normal in spite of the most modern means of diagnosis at the command of their physicians—namely, percussion, auscultation, x-ray study, electrocardiogram tracing, and comparison with the effort-syndrome type and cardiac hypertrophy group of Christian. When subjected to graduated physical tests for heart muscle response, however, they were found to be considerably below standard, and they substantiated the correctness of this presumption by making satisfactory response to rest and a cardiovascular building-up régime.

Tonight, I wish to invite your kind attention to still another important type of myocardial disturbance, or heart muscle let-down, which apparently is occurring with increasing frequency and which should be recognized. I refer to the great myocardial upheaval of com-

pensating hearts which frequently follow in the wake of mild infections like grippe. The most dramatic instances of this occur in hearts which, although not normal beforehand, have usually been compensating uniformly and satisfactorily over a long period of time prior to this particular infection. A case of this type was referred to by Dr. William S. Thayer, in discussing my paper at the A. M. A., and I have found similar myocardial disturbances following attacks of grippe in patients of my own.

There is one thought which I should like to leave with each one of you tonight, if I accomplish nothing more; that is, if we are to hope to remove heart disease from the exalted position which it now occupies at the head of the mortality list, we must turn our diagnostic attention more and more toward general disturbances of the heart as important causes of cardiac deaths, and less and less toward organic valvular lesions or cardiac murmurs alone. Myocardial disturbances or heart-muscle weaknesses, occur far more frequently during infections than do valvular lesions, and to my mind suggest a much more tangible explanation of the great increase in the incidence of cardiac deaths during recent years than any other form of heart disease possibly could.

The question of correct diagnosis, when considering deaths attributed to cardiac disease, is, of course, most uncertain. It is so easy to say that so-and-so died of heart disease because he was found lying dead on the floor, and to give no further thought to the matter. There is much dependable data at our command today, however, if one cares to look for it, which points strongly toward the fact that deaths due to cardiac disease are actually on the increase.

If one reviews the literature dealing with the history of influenza, he will find that this particular infection has usually appeared in pandemic form at well-defined periods, and has rapidly swept from one side of the globe to the other. Following each such world-wide invasion, there has been a lull for a number of years. Following the pandemic of 1918, however, came several minor outbreaks, or local epidemics, in various sections of the United States, which differed from the pandemic only in that the later cases did not develop the streptococcus pneumonia which caused so many of the earlier deaths. Moreover, the cases in 1918 which were free from streptococcus pneumonia were similar to the active grippe cases we see now. In other words, the only difference between the pandemic period and today, as I see it, is the absence of pulmonary complications. The type of grippe which we are now having behaves in many ways like a systemic infection and is, by reason of that fact, capable of producing whatever type of body mischief neglect or improper care may allow.

I believe it was Professor Osler who once said that he who understands syphilis and typhoid fever and their many complications is well equipped to practice medicine. To this brilliant thought one might add today that he who treats grippal infections should anticipate every complication to which the body falls heir. Just what grippe does to the average heart, I do not fully know. Clinically, it fits into the category of myocardial weakness. My own feeling is that all the parenchymatous organs suffer during acute infections like this, and the type of heart to which I am attempting to call your attention suffers more than most other organs because it has been damaged previously and is the only organ not allowed to stop its function from birth until death.

That many organs of the body may be involved at the same time during a given acute infection like grippe, at least toxically, is supported by the finding of a trace of albumin in the urine, an increase or decrease in the number of white blood cells, or the general let-down in mental acuteness and the irritated or sympathetic changes that occur in the respiratory and gastro-intestinal system and which are difficult to explain otherwise. Call such changes "cloudy swelling", in the name of the pathologist, if you will; the fact remains that these disturbances actually take place in all these sensitive organs at that time, whether recognized or not. Now, add to this picture a heart which was not normal to begin with and which has been subjected to many bacterial insults, and, although it may have compensated adequately for years and may be free from the original bacterial focus which caused the damage to it, you have a heart which is

called upon once more to meet a great strain. A break in compensation follows because the heart cannot stop beating long enough to permit its damaged muscle to undergo repairs. It is the heart muscle, after all, which finally determines the prognosis. The valves may be deficient or incompetent to an alarming degree, but so long as the muscle power holds out, the patient will survive.

Hence, I wish to make a plea for greater consideration and more earnest care for these already damaged hearts, both during illness and throughout the convalescent stage of even the mildest forms of grippe, if we wish to accomplish more in the handling of cardiac diseases in the future than we have done in the past. They all present symptoms which are indicative of a let-down in heart compensation, but, because they occur in such apparently trivial infections as grippe, they may escape our notice or not impress as being worthy of serious thought.

As pointed out before, if you will only devote a few moments of your time to making a written record of the heart tone, heart rhythm, apex beat and blood pressure of each patient upon his first visit, you will not need to be an expert diagnostician to realize that the circulation is disturbed when these changes occur.

Why is it that most men do better work for their hospital patients, even though not members of the staff? Mostly because of greater care in carrying out hospital routine and careful charting. A few days of this, and the picture becomes clear.

Report of Cases

A typical case is taken from each of 3 well-known groups of heart disease which are seen by many of you from day to day: (1) A patient with chronic rheumatic endocarditis, who had been free from fever, active cardiac signs or joint involvement for about 8 years prior to the onset of grippe; (2) a patient with chronic myocarditis which followed recurring attacks of follicular tonsillitis; whose heart fibrillated 2 years later, but who responded to treatment and remained normal in rate and rhythm until taken ill with grippe; and (3) a patient with chronic myocarditis without apparent cause, who had shown some impairment of muscle strength for years, but through careful living had compensated uniformly and satisfactorily for about 4 years.

Case 1. H. K., white, male, aged 42, former lumber operator, complained of rapid pulse, shortness of breath and inability to lie down. Family history was negative; past history unimportant, except for recurring attacks of rheumatic fever. At the age of 19 he was taken with the first attack of this fever, which involved his left wrist and elbow and, later, his left ankle. This kept him incapacitated for several weeks, but he finally recovered. Two years later he had a second attack of rheumatic fever, when his physician found that his heart had developed a distinct mitral murmur. About 3 years later he suffered a third attack, with active involvement of his tonsils, and was ill for many weeks. Following this, his tonsils were removed, because of the heart involvement, and he felt much better.

On account of his inability to perform active work, he came to the seashore to live. Physical examination at that time showed a fairly well nourished male whose chief disturbance centered about his heart. There was an increase in the transverse diameter of the heart, with the apex in the nipple line in the fifth interspace; also a loud systolic murmur at the apex, which ended with a sharp crescendo snap and which was heard over a limited area. The pulmonic second sound was accentuated. Pulse rate was 76 and blood pressure 130/90. There was no edema of the lungs or ankles, and the liver was not palpable.

The patient's present illness began suddenly, with an attack of aching pains of arms and legs, hoarseness, and hot and cold sensations. Pulse was 90; temperature 102.5; respirations 20; lungs negative throughout; and heart findings practically the same as formerly, except for increased rapidity. The next day his temperature rose to 103. On the third day he perspired freely and his temperature fell to subnormal. That night he developed a dry cough; his pulse went up to 130 and became irregular; lung bases were full of moist râles; blood pressure fell to 105/80; and patient looked as if he could not survive. Heat, cardiac support and sedatives helped him surmount the crisis,

but for many weeks he was unable to get about. He is at present in Florida.

Case 2. L. F., female, aged 50, complained of aching pains over the body, shortness of breath and a dry cough. Family history was negative; past history unimportant, except for attacks of irregularities of the heart several years previous, which were diagnosed as auricular fibrillation. One week prior to patient's present illness, she was in Chicago on a visit when taken suddenly with an attack of grippy pains, sore throat and temperature of 103. She went to bed and took a cold remedy capsule. On the fourth day she perspired freely and her temperature became normal. She was anxious to get home and left that night by train. During the trip she became weak and short of breath, and thought she was going to die. When seen by me upon her arrival, she presented all the classical symptoms of acute decompensation—enlarged, feeble heart, rapid pulse, moisture at both lung bases, and low blood pressure. After 6 weeks in bed she was able to be up and about but could not overdo.

Case 3. Male, aged 58, retired business man, complained of great pressure in his chest, shortness of breath and a dry cough. Family history was negative; past history unimportant except that he was never physically fit. About 6 years ago he began to observe that he would tire upon exertion, so he gave up his work and came to the seashore. Physical examination at that time revealed a heart which was neither dilated nor hypertrophied, but the sounds were a bit distant and "tic tac" in nature. Pulse was 76, and blood pressure 118/90. He kept out in the open, walked each day and seemed none the worse from this form of exercise.

About 4 months ago he was taken with aching pains, headache, and hot and cold body sweats. His temperature was 102, pulse 90, and respirations 22. A cold capsule was given, and on the third day he perspired freely and his temperature fell to subnormal. The following day he went to the bathroom to pass a stool and became faint and weak, his pulse became almost imperceptible, and he scarcely got back to bed. When seen by me, his pulse was 120, heart was dilated, the bases of his lungs were full of fine moist râles, and blood pressure was 100/80 and poorly supported. For days his life held by a thread and he is still quite weak, but is able to be about most of the time.

Summary and Conclusions

(1) Many physicians still regard grippe infections as general colds, and, because the pulse rate is normal and fever has subsided, allow their patients to get out of bed before the toxic damage to the organs has been repaired.

(2) There is considerable clinical evidence that grippe infections attack all the parenchymatous organs of the body in a most active manner, and, if the patient is not carefully guarded, they may prove to be the terminating factor where the heart is already weakened.

(3) As soon as the medical profession realizes that myocarditis is far more common than organic valvular disease, just so soon cardiac disease will be lowered from the exalted position it now occupies at the top of the mortality list.

(4) Could it be possible that the great increase in incidence of cardiac deaths during recent years might be due in part to the increase in number of grippal infections, which frequently attack hearts that have been previously damaged and are not always guarded with sufficient care during the convalescent stage?

NATIONAL HEALTH INSURANCE OF ENGLAND APPLIED TO THESE UNITED STATES*

Archibald Sinson, M.D.,
Brooklyn, N. Y.

It is indeed not only an honor and a privilege, but a real personal pleasure for me to present here my views concerning the solution of the present impasse that confronts our profession. Having been born and educated in England, and having 3 older brothers enjoying there the benefits of the "Panel System" from its inception, and myself having graduated here in the United States and practicing

*(Read before the Brooklyn Medical Alliance, February 27, and, in part, at the Union County Medical Society Meeting of February, 1933.)

8 years, I could not fail to be influenced by both systems. I have seen, and have been influenced by, the gradual evolution of the National Health Insurance scheme in England from its very beginning in 1911, all through the unavoidable vicissitudes of its early stages; the development by the slow and painful process of trial and error; the elimination of its early blunders; all the long road to its present satisfactory form—satisfactory both from the viewpoint of the medical pocketbooks and the health of the nation. At the same time, in my own medical career here in the United States, I have also lived through the haphazard so-called "prosperity years" where medicine was regarded and was being conducted as a business, swayed and influenced by the economic stresses and strains of an extreme capitalistic system, and subject to the same deplorable risks concomitant with all other economic enterprises.

I may, at the outset, sound a pessimistic warning—I fear, contrary to general opinion—that the time is not *ripe for change;* i. e., a change which we ourselves can influence; *the time is over-ripe.* By that, I mean that we really missed our opportunity for effecting radical changes for our economic security during those halcyon days of superficial soundness; and at the present crisis it would appear that, not sound reasoning nor keen observation nor clear thinking, but "empty bellies" are clamoring for some solace and relief, with the painful consequence that at any moment public opinion may be getting more and more reconciled to the spectacle of lay politicians in the State's capitol, drafting members of our profession, like dumb driven cattle, into an extreme socialistic experiment without our having anything whatsoever to offer by way of defense. Now, "empty bellies" are not edifying spectacles. To be sure, they may drive groups of people to extreme measures, but where the nation's health is at stake, the economic plight of the individual practitioners is of little concern; time's necessities will prove to be severe task-masters and will be as indifferent to our personal comfort as the overpowering growth of big capital in the form of trusts and combines was to the individual merchant and trader. From the outset, therefore, I wish to be explicit on this one point: that were all industries, economic activities and professions to become State-owned, or nationalized, I would be the last person to offer any other alternative so far as medicine is concerned. It would be sheer folly on our part to endeavor to stem the rising tide of socialism; we would simply be committing economic suicide. But, so far as I can see, ours is the first profession that is threatened with experimentation on State lines, while all other activities and vital necessities remain exempt. To be the first rabbit inoculated with the new disease germ is not very flattering either to our sense of honor or decency or station in society. It would amount to a 50-50 guess whether we turn out to be the greatest goats or the greatest pioneers in this topsy-turvy world. A 50% chance of being annihilated is not even a risk that the most radical surgeon would dare take, especially if, in the interim (i. e., during the process of change), a half-way stage could be arrived at, whereby the medical profession could be organized and still retain the rights and privileges of private practice, thereby rendering it prepared and ripe to climb onto the band-wagon of the future State socialism without incurring immediate suffering and chaos—and, above all, during that transitional period the individual doctor would be a part-servant of the community and free from economic distress. *Make no mistake about the seriousness of the public's unexpressed* but *simmering clamor for some* form of medical disciplining and organization. The form that it will eventually take will depend primarily on the speed with which we can draft, by propaganda and absolute unity, a better alternative scheme to promote and protect public health and at the same time preserve and increase our own economic security.

In my effort to stimulate you to some action on those lines, I wish to parallel the methods adopted by our early revolutionary fathers who drafted the first Constitution. Confronted with the task of deciding on the exact form of political government to be adopted, they did not begin at the point from which their forefathers began. They, so to speak, "jumped" the centuries of gradual growth of liberty (the early Witenagemot of the Saxons from

the fourth to the twelfth centuries; the Magna Carta period from the twelfth to the fifteenth centuries; the famous Bill of Rights of 1688) and mapped out a scheme of governing which retained all the good qualities of democracy and avoided the pitfalls and errors, and retrogressions, that were the natural concomitants of the Anglo-Saxons' uphill fight for freedom.

We are now in the happy position of viewing the experiment of the National Health Insurance Act in England, in 1910, in retrospect, and we too can adopt a plan which will avoid the early pitfalls, errors of omission and commission, which characterized the period of 1910-1930, and arrive at the stage of success that it has now attained—a success that is emphasized by the attitude of the British Medical Association in its introduction of a Bill, which is now pending in the House of Commons, demanding the state to include all classes of earners, irrespective of whether they are working-, middle-, or higher-class employees, into a more comprehensive National Insurance Act. Twenty years of evolutionary development of State health has been enough to convert the British Medical Association (that august conservative body) from a violent antagonistic attitude to a pioneering partisan one; and, it is that period of 20 years that I am asking you to jump when you have considered this plan more thoroughly.

Briefly, the British National Insurance Act (or Panel, as it is sometimes called) came into effect in 1911, and, from the violent opposition to it by the British Medical Association, it was doomed to mistakes and failures in its initial years. The impression that those early blunders made on us here in the United States still lingers, and all its subsequent successes do not seem to have eradicated it from our minds.

Only working people from 16 to 65 years old, with a maximum earning capacity of £3 a week, were eligible under the Panel scheme. Each worker paid 9 pence a week, each employer of that worker 9 pence a week, and the State paid the third pence a week per worker, which made a total of £6 a year for each worker. In proportion to our standards of living, it would be equivalent to about $50 per year. With that sum paid into the State, the latter furnished free medical service to all these people, and in addition paid them compensation for time lost through illness from the fourth day onward. Owing to the British Medical Association violently opposing the whole scheme, the Panel doctors were, at first, mostly young graduates with no hospital experience. So, the early failures were attributable more to the conservatism of the profession rather than to the impracticability of the National Health Insurance Act. The doctors received 10 shillings per head per year; i. e., one-twelfth of the total fund, and the average number of each doctor's list was from 1500-1800 individuals. That insured a definite income of between £800-£900 per year, from that work alone. The private practice from the families and dependents of the insured worker usually amounted to the same sum so that in all his income was in the neighborhood of $15,000.

The early mistakes in the actual administration of the scheme were briefly as follows: (1) Worker could not change his doctor for a year, and then only through a good deal of red-tape-procedure. (2) Difficulty of adjusting disagreements between doctors and workers as to time and hours available for services. (3) Medical men mostly young and inexperienced. (4) Opposition of the British Medical Association, with the consequent difficulty of getting the coöperation of hospitals and specialists in difficult cases for reasonable fees. (5) The anti-propaganda of the conservative press. (6) Control of the pharmacists—difficulty in checking the honesty of correct dispensing of Panel prescriptions. (7) Difficulty of checking collusion between worker and physician. (8) Night work was somewhat haphazard—doctors often pretending to be on other private work, and the most common excuse being obstetrics.

The great advantage to the doctors was the fact that only about 15% of the workers on their lists would be treated, at some time or other, during the year; which gave them the monetary incentive to prevent disease and cure their patients with all possible speed. This led to the inevitable added interest that young doctors displayed in the realm of preventive medicine. The constant opposition of the British Medical Association finally drove the

"Panel doctors" to organize into an opposition trade union, as it were, with its own Journal, its own press, its own propaganda; and each year saw the percentage of physicians on the Panel increasing—from an initial 30% to the present 90%—and the conservative element finally giving up the ghost and reconciling itself to the new trend. Many, or most, of the early abuses gradually were eliminated in the measure of more and more unity in the ranks of the profession itself; and then the State enlarged the scope of medical benefits by the inclusion of obstetrics and regional specialists—each specialist to every 5 general practitioners with the same remuneration.

In view of the present threat hanging over us—in the form of State service—organization of the medical profession, for the purpose of offering and demanding an alternative scheme, seems to me imperative, and it should transcend all other activities which do not go to the very roots of the controversy. It is my personal belief that this very organization you have (County Society) is an ideal one to begin with; but, if it is merely for the purposes stated in your provisional platform, I am afraid that you are merely clutching at straws. The prevalence of cheap and free clinics, interferences by lay politicians and insurance companies, etc., are not material nor vital factors; and they are by no means peculiar to the United States—they are prevalent all over the globe. *Don't lose sight of the fact that the abuses, and ill-effects on the private practitioner's economy and well-being, were all lessened, practically eliminated, by the National Health Insurance Act in England; and there is nothing to prevent an organization like this from mapping out a similar scheme, with a few alterations here and there, obtaining the signatures of the bulk of the profession to bolster it, and presenting it in the form of a petition to the State authorities.*

We have not yet reached the stage where the political and economic thinkers high up are really very anxious to adopt extreme socialistic measures in medicine, and, if they are finally reluctantly driven to it, it will be primarily due to lack of a better alternative. Time is getting short and we must act quickly and give our whole-hearted energy and support to a scheme whereby we become organized, have the health of the people protected against lay graft and corruption, and the profession itself secure from economic anxiety; and thus meet the present tendency half-way, and be in direct line for any radical or socialistic tendencies coming through other fields; and if in the distant future the whole fabric of society will have to surrender to State centralization, it will not at that time cause the chaos and confusion among us that might ensue if we lacked organization entirely.

Sketching a Plan

Let us take a hypothetic illustration as to the approximate manner in which such a plan would have to be formulated for the Borough of Brooklyn. All these subsequent figures are purely guesses and subject to changes, obviously, as I have no exact data at hand. Let us suppose that there are 750,000 workers, including all men and women between the ages of 16 and 60, of all classes—professional, business, artisan, and laboring. Each pays to a State fund compulsorily 25 cents per week, or $12 per annum. Each employer pays same amount per employee, $12 per annum. The State pays the other third out of taxation, $12 per annum. Total fund would be $36 per employee per annum, or $27,000,000. The total area of Brooklyn to be divided into 100 medical districts; 5 doctors allotted to each district so that each would be responsible for the care of 1500 workers, the remuneration for which would be $6 per head per annum, totaling $9000. Private practice to be allowed but only among the immediate dependents of insured (wives and children), the income from which, judging from English statistics, would be between 70 and 100% of income derived directly from the State. The total earning capacity would be, therefore, in the neighborhood of $16,000-$18,000 per annum. Medical appointees would be chosen from general practitioners passing the 5-year period following graduation from a Grade A Medical School, with age limits of 25-65 years, and 25 years' service entitling him or her to a reasonable pension.

The 100 districts to be subdivided into 10 regions, each containing 1 regional specialist

for the following specialties: orthopedics; radiology; eye, ear, nose and throat; venereal; general surgery; gynecology. That is 60 regional specialists in all, the remuneration being $1 per head per annum, or $12,000. The restrictions as to private practice would not apply to these specialists.

Each doctor compelled to allot at least 3 hours of office work per day except Sundays and holidays, and excluding the time taken up for outside calls. All calls coming in before 9 a. m. to be executed before lunch; subsequent calls to have a time limit of 8 p. m. Calls between 12 midnight and 7 a. m. to be regarded as night calls, for which special provisions are provided. These calls will be executed through the Central Health Office, where a rotating service will be mapped out so that each doctor will have a certain night per week, or fortnight, as the case may be, on call for such emergencies.

Maternity work among women workers or wives of insured to be carried out by the general practitioner at an extra remuneration of $50 per case.

Facilities for easy transfer of insured person from one doctor's list to another. One month's notice, executed in writing, to the Central Office should be all that is required and no reasons necessary; but the free choice should be limited to the other 4 physicians in the same district.

The 100 districts to be divided into 5 main sections—north, south, east, west, and central—each of which containing a Central Laboratory and Dispensary where all insurance prescriptions will be dispensed and all necessary laboratory analyses executed. This may work a temporary hardship on neighboring pharmacies, but in a plan of this kind all avenues or possibilities of graft and corruption must be avoided from its very inception. Where there is no monetary advantage to be gained, there can be no incentive to dispensing incorrect ingredients; and it must be admitted that no profession is immune from this human equation—even our own did not escape untarnished from the liquor prescription scandal.

Each borough will have a central office at the head of which I, personally, recommend a medical man with real administrative capacities whose income should be high enough to be beyond the possibility of any questionable tactics; for a district as populated as Brooklyn, anything less than $25,000 would be courting trouble.

Roughly speaking, therefore, we would have a total fund of $27,000,000 divided into the following gross activities:

General medical services	$ 4,500,000
Specialist medical services	500,000
Dispensing and laboratory	1,000,000
Administration and central office	1,000,000
Sick benefits and hospitalization	20,000,000

The time is much too limited for me to go into any further hypothetic details, but I believe and trust that I have given you some conception of a reasonable plan which might stimulate you to further organization and action. New York and vicinity may not be ideal centers for experimentation on Panel lines, owing to its tremendous shifting and fluid populations; in which case the State may decide to try it out for a year or so on some upstate town, e. g., Rochester, Syracuse, or Buffalo, and thus perfect the whole scheme of Health Insurance before tackling such a major problem as New York City. However, and this is the crux of the whole matter, the lay minds must be educated and attuned to the whole conception of State Medical Insurance just in the same manner as they are now being stimulated to think in terms of Unemployment Insurance; and that will only be accomplished by absolute unity of purpose in our own ranks, by constant and perpetual propaganda by us, and our refusal to being sidetracked and lost among a maze of petty abuses and details that have arisen as a result of the gradual ineffectiveness and break-down of the old order of things. To be thoroughly aroused, to be in the vanguard of progressive changes, to be a real live and stimulating force in the upper stratum of society, impels us to become modernistic enough to likewise demand—*a new deal.*

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

NOTE.—The transaction of business will be expedited, and prompt attention secured if:

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to The Editor, DR. HENRY O. REIK, Vermont Apartments, Atlantic City, N. J.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent to THE CHAIRMAN OF THE PUBLICATION COMMITTEE (address above), Newark, N. J.

MORE ABOUT THE COSTS OF MEDICAL CARE

The Editor, desiring to serve the best interests of his constituency, the approximately 2800 members of the Medical Society of New Jersey, has had to deal with a series of perplexing problems during the short interval of time since the so-called "Wilbur Committee's Report" was made public. With no specific plan of procedure arranged in advance by or for "organized medicine", there arose almost immediately and quite spontaneously, it seemed, a tacit understanding that: all members of the medical profession should study that "Report" and present their views and opinions to their respective County Societies; where the collective personal attitude would be arranged for transmission to the State Society; and that organization would, in turn, assimilate the County reports into a State recommendation for passage along to the American Medical Association; which, after a proper period of study, would become fitted to speak authoritatively for the physicians of the Nation upon a question of national import.

That is, theoretically at least, the American plan for determining mass opinion. If our national organization desired to learn the views of its individual members, no better method could be employed. Upon that assumption, it became necessary to give thought immediately to an important question—are these members prepared to express opinions upon such complex economic problems as are involved in this matter? We doubted it, because we had observed on many occasions prior to November 1932 that the *average member* of the profession seemed to hold but the vaguest ideas concerning any of the economic problems affecting even his own practice; of course, there had been little occasion for him to think of them and less opportunity to study them. So, we set about the task of supplying him with pertinent information.

In the January Journal our members were given most of the essential knowledge bearing upon the present pressing problem. In this issue we are offering further help; in the form of additional facts for their edification; and, by means of reports upon the manner of dealing with this matter in other States. Read it, please, for your own benefit.

Medical Ethics

CONSULTANT AND ATTENDANT

John Hammond Bradshaw, M.D., F.A.C.S.,
Orange, N. J.

When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation—Prin. Med. Ethics, A. M. A., Art. IV, Sec. 1.

To this we all can say—amen! Yet, the writer believes that every one who reads this article has, personally, lost a patient to the consultant whom he—*himself*—has called in as consultant to help him. It is so easy to say that "circumstances alter cases", but a good deal of the hard feeling between doctors has been brought about by fracture of this rule. It is not to our credit that this should be the case. Probably any hundred physicians, if asked whether or not they subscribe to this law, would affirm that they always do so and believe that the man who breaks it is unworthy, unreliable, and should not be given a seat of honor at the table of ethics.

Even the writer has had a number of sad experiences that almost curdled his milk of brotherly love. Here is just one: One night, an old patient (not old in years) summoned him hurriedly for an acute attack of illness that was seen immediately (and without any diagnostic acumen) to be that of an acute appendix. An immediate operation was suggested and even demanded. The patient was willing to have an operation; but, with the reasoning that $2 are better than $1 this patient requested 2 opinions before he laid his sacred body on the table. A prominent surgeon in a nearby State (only a few miles away) was suggested, and the writer was much pleased that a name of such prominence (and an old friend) was suggested. After waiting by the bedside until the arrival of the distinguished surgeon, it was with deep satisfaction that all the findings and diagnosis of the first physician were confirmed. Moreover, an immediate operation was advised. The writer thereupon left the room (with the consultant still there) and betook himself to his own hospital, where he made all the usual arrangements for a speedy operation, even to the engagement of 2 nurses (as the patient was wealthy). He then went to his own home for a hasty supper, as he had appointed the operation for 7 o'clock that night. While eating that meal, he received a telephone call from the noted consultant, and was not a little taken aback to be told that *the patient* had decided to have the consultant perform the operation, and that he (the consultant) had accordingly taken the patient to his own hospital and would like to have the writer assist him in its performance.

Now, can the latter be blamed if, after having made all the arrangements, even to engaging an anesthetist, the operating room and the nurses, for his own operation, he felt justified in not accepting the kind invitation? Had the writer not been himself a surgeon who had performed the difficult (?) operation of appendectomy many hundreds of times, perhaps his humility would have been such that he would have accepted this humiliation.

Testimonials

DR. J. FINLEY BELL, OF ENGLEWOOD, AT THE CONCLUSION OF 50 YEARS IN PRACTICE, HONORED BY ASSOCIATES

At the Hackensack Elks' Club, his Bergen County friends paid to Dr. J. Finley Bell a tribute of respect and affection, at the end of a half-century in the practice of medicine.

Dr. Bell was graduated March 13, 1883, from the Medical Department of the University of the City of New York.

Lecturing at the Englewood Woman's Clubhouse that day, was Dr. Amos P. Squire, who knew of Dr. Bell's work in the Hospital for the Insane on Ward's Island and at Morris Plains. He had arrived in Bergen County for the sole purpose of lecturing, but when he heard that Dr. Bell was being honored at an Englewood home, he joined in the tribute.

Since 1901 Dr. Bell has lived in the same house at Englewood and practiced among the same dwellers of that city, serving at different periods on the staff of Englewood Hospital, founding the Babies Dispensary of Englewood, which, in 1914, 4 years after Dr. Bell had left Englewood Hospital staff to found it, was incorporated into the hospital.

Views New Principle

At present, socialization of practice engages him most. When this departure was recommended some months ago by the Committee on Costs of Medical Care, Dr. Bell accepted the theory as sound, while many a younger doctor who should have been more resilient to ideas than he, opposed it.

Dr. Bell even surmises that it would not be such a departure as it has been pictured by rebellious doctors, since certain communities

now guarantee a specified salary to better doctors than they could attract there otherwise, and supply him with experimenting equipment and an automobile.

"It would free a physician", said Dr. Bell, "from devoting to *how bread and butter may be earned,* a mind that belongs, by dedication, to medicine, and that is something for which any doctor should be glad."

Believes in Theory

"I am a Socialist in all things," he adds, "and so in principle I am bound to the Socialization of Medicine. I can see why certain physicians might balk at being the first profession to be experimented with in such a de-



J. FINLEY BELL, M.D.

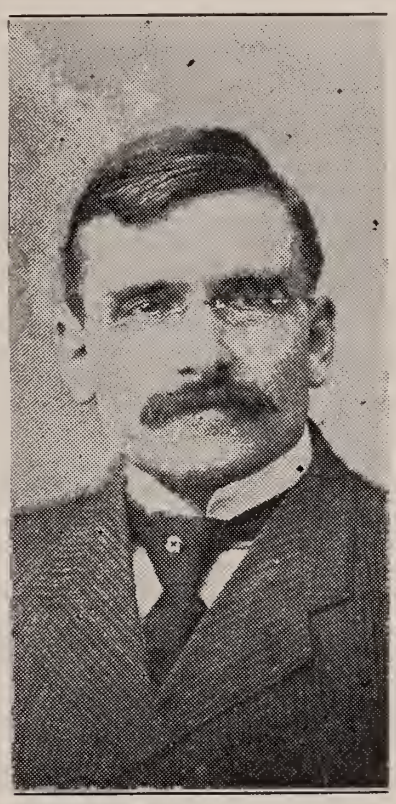
parture, but somebody has to be the subject of an experiment, and I don't know why it shouldn't be the inveterate experimenters."

DR. ELTON S. CORSON, OF BRIDGETON, HONORED FOR DISTINGUISHED SERVICE

For charitable work in connection with his profession during this time of economic stress for so many people, Dr. Elton S. Corson was presented with the Trophy, given annually, by Shoemaker Post, American Legion, for outstanding community service or achievement, the presentation featuring a patriotic service held Sunday evening at the First Baptist Church.

The presentation was made by Corporation Counsel, Samuel Iredell, in the presence of a representative audience of about 150, including many members of the Post. Both men, who had been at South Jersey Institute and Bucknell College together, were visibly affected by the time the presentation was over.

Prior to making known the name of the recipient, Mr. Iredell referred to their relationship as school-mates at South Jersey Institute and college-mates at Bucknell University, and then paid a tribute to the service which led to the awarding of the Trophy; telling how the physician had cared for the sick, responding to all appeals and calling Dr. Corson from the rear of the church, presented the Plaque adorned with the Legion insignia.



ELTON S. CORSON, M.D.

The Appreciation

Expressing gratitude and appreciation of the honor, Dr. Corson modestly said: "I think of many names that could be given, of persons who are just as worthy of the award"; and at the close of his response the audience arose spontaneously, and stood in tribute to the man who has the reputation of never failing to respond to any call to aid the sick or suffering. While it in no way affects the decision concerning this award, which is for services during 1932, it was learned from an outside source that during the past week Dr. Corson made 115 sick calls for which he has no expectation, even, of receiving compensation.

Special Article

MORE ABOUT THE COSTS OF MEDICAL CARE

The object of the January Journal was to place in the hands of every member of the Medical Society of New Jersey the essentials of the "Report of the Committee on Costs of Medical Care"—not only the Majority and Minority Recommendations, but the facts upon which those recommendations were based—in order that each member could draw his individual conclusions and formulate his own recommendations; because, to accept any series of conclusions without searching into the material upon which those conclusions are based, is to negate all the resources of one's own mind.

In this article, an attempt will be made to place in the hands of our members further material on this moot subject, material which has been published since the appearance of that *Report,** and which has happened to fall under our observation. Thereby, each member can further equip himself for intelligent discussion at the Annual Meeting, to be held in June. This material will be grouped into the following divisions:

(1) Reference list of articles relating to this aspect of medical economics published in the Journal during the past 5 years.

(2) Addenda to the list of books dealing with the problem, suggested for reference reading on page 36 of the January Journal.

(3) The reaction of the public to the *Report,* as indicated by news-paper and magazine editorials.

(4) The reaction of the Journal of the American Medical Association.

(5) The reaction of the profession at large, as shown in other State Medical Society Journals, including any action taken or planned for the future.

(6) The reaction of Component Branches of the Medical Society of New Jersey, as shown in County Society Reports and Bulletins.

(7) Miscellaneous items bearing upon this problem.

(1) Reference list of articles relating to this aspect of medical economics published in the Journal during the past 5 years:

1928

Medical Economics, M. L. Harris, Feb., p. 134.

Contract Practice, M. L. Harris, Mar., p. 216 (President A. M. A. concerning high fees).

Private Practice and Preventive Medicine, Sir Arthur Newsholme, Apr., p. 272.

Medical Costs, July, p. 495.

Dr. Wilbur Shows Need of Medical Care Cost Probe, July, p. 496.

Group Practice, Oct., p. 662 (Will Mayo describes what it should be).

1929

Cost of Medical Care, July, p. 548 (Wilbur).

State Medicine: Boon or Bogy, Dr. G. W. Haigh, Oct., p. 693 (State Medicine organized on the basis of the U. S. Navy Medical Service).

Group Practice in Medicine, Dr. Joseph Collins, Dec., p. 858-866 (excellent article, reproduced here from Harpers Magazine by special permission of the author. In this article and in his book entitled "The Doctor Looks at Life and Death", Dr. Collins presents the most logical argument we have ever read favoring group practice).

1930

Group Practice, W. L. Love, Jan., p. 50.

Contract Practice, Feb., p. 144.

Autocare vs. Medical Care, Edward A. Filene, May, p. 454 (written for Survey Graphic with special permission to us to use in Journal).

Industrial Medicine, Carey P. McCord, May, p. 459 (Excellent. From A. M. A. Bulletin.)

Medical Economic Solutions, June, p. 554.

Committee on Cost of Medical Care (report by A. C. Morgan), July, p. 612.

Economic Conditions in Relation to Medical Organization, A. H. Frieberg, Sept., p. 741.

Increasing Efficiency, Reducing Cost and Improving Our Professional Status, Henry O. Reik, Nov., p. 845.

Comparative Expenditures for Medical Care, W. C. Rappleye, Dec., p. 993.

1931

Medical Travel Talk, Henry O. Reik, Jan., p. 42.

The Public Relations Committee, Jan., p. 55.

Medical Service of the Future, Reik, Feb., p. 132.

Medical Travel Talk, Reik, Feb., p. 135.

State Medicine and Control of Specialism, John A. Hartwell, Feb., p. 168 (Presidential Address, New York Academy of Medicine).

Medical Travel Talks, Reik, Mar., p. 246; Apr., p. 355; May, p. 427.

Editorials on State Medicine, Apr., p. 352; Aug., p. 662.

Are We Facing Social Control of Medical Practice, Aug., p. 674.

*(To save space, let it be understood the word—*Report*—in italics, means the Final Report of the Committee on the Costs of Medical Care.)

How French Dentists Met the Insurance Question (Dentists' Association), Sept., p. 723.

Smith Urges Health Insurance, Nov., p. 877 (message from "Al").

1932

The Genesis of Social Insurance, Edward H. Ochsner, Jan., p. 78; Feb., p. 171; Mar., p. 269; Apr., p. 358; May, p. 431; June, p. 510; July, p. 603; Aug., p. 677; Sept., p. 708; Oct., p. 806; Nov., p. 874; Dec., p. 974.

Costs of Medical Care Discussed at New York Academy of Medicine, Apr., p. 351.

Medical Costs, Apr., p. 355.

Costs of Medical Service Seen as Problem for Organized Profession to Solve, Ray Lyman Wilbur, May, p. 424.

Proposal of State Medicine, S. A. Tannenbaum, June, p. 507. (A definite plan for medical care on same basis as education.)

Some Factors in State Medicine, H. S. Baketel, July, p. 538 (good review of present conditions).

Insuring Hospital Care and Costs, C. R. Rorem, Aug., p. 665.

1933

Preventive Medicine from the Standpoint of the Internist: Its Value for Public Health, Lewellys F. Barker, Jan., p. 29.

Editorials, Jan., p. 37.

Liberal Abstract of the Final Report of the Committee on the Costs of Medical Care, Jan., p. 39.

Public Presentation of the Medical Costs Report, in Addresses by N. B. Van Etten and Lewellys F. Barker, Jan., p. 76 and p. 79.

Principles and Policies of Organized Medicine, William Allen Pusey, Jan., p. 81.

Tri-State Medical Conference, Jan., p. 82.

Minutes of the Welfare Committee Meeting, Jan., p. 119.

List of Books on National Health Insurance, Jan., p. 36.

As the Doctor Sees His Profession, E. G. Hummel, Feb., p. 146.

Problems for the Doctor, F. I. Krauss, Feb., p. 143.

Editorials, Feb., p. 156.

One Hundred Years and After, Address Delivered by the Right Honorable Lord Dawson of Penn, at the Centennial of the British Medical Association, in London, July 1932, Mar., p. 257.

Editorials, Mar., p. 255.

National Health Insurance of England Applied to These United States, Archibald Sinson, Apr., p. 332.

Report of Tri-State Medical Conference, containing description of the Endicott-Johnson Clinic, and article on the Report of the Commission on Medical Education by its Director, Dr. Rappleye, in this Journal.

Statement by Dr. J. Finley Bell at celebration in honor of his 50 years in practice; in this Journal.

(2) Addenda to the list of books dealing with this problem, suggested for reference reading in the January Journal, p. 36:

The Doctor Looks at Life and Death, by Joseph Collins, Farrar & Rinehart.

How to Budget Health, by Evans Clark, Harper & Brothers, 1933, $4.00. Reviewed in this issue of the Journal, Department of Collateral Reading.

Final Report of the Commission on Medical Education, Chairman, A. Lawrence Lowell. Privately published by the Commission, 630 W. 168th St., New York City, $2.50. Reviewed in this issue of the Journal, Department of Collateral Reading.

(3) The Reaction of the Public to the *Report,* as indicated by news-paper and magazine editorials:

Ladies Home Journal and Saturday Evening Post editorials, opposing Majority Recommendations, quoted in February Journal, p. 156.

Boston Evening Transcript, New York Herald-Tribune, Dallas Morning News, New York Evening Post, and Philadelphia Record editorials, quoted in Journal of the American Medical Association, Dec. 10, 1932.

HEALTH INSURANCE

(Editorial in New York Times, March 18, 1933.)

The Committee on the Costs of Medical Care, after long study, recommended "sickness insurance" as a voluntary and community provision. But Mr. Albert G. Milbank, the President of the Milbank Memorial Fund, which has been serviceable to the public in making experiments in promoting community health in various centers, has urged that unless the scheme is compulsory and at least Statewide, the results hoped for will not be achieved. He does not suggest the details, but recommends the appointment of State commissions to work out through coördinated effort such a plan on a contributory basis. He will find encouraging precedent in the English system, which, according to Dr. McCleary, of London, England, former Deputy Union Medical Officer of the Ministry of Health, has met with "the hearty approval" of the British Medical Association and the "enthusiastic coöperation" of the medical profession at large. The effect has been to raise the quality of medical service.

This scheme is of advantage financially to the physicians (15,000 in number, comprising about 70% of the total number of practitioners in the country), ministering to about 38% (15,000,000 in England and Wales) of the total population. One feature of the plan which must especially commend it to those who fear that medical service may become perfunctory and impersonal is that the insured may choose each his own physician. The "family physician" may thus be kept under this plan. On the other side, the physician is paid out of the common fund and does not have to worry over collec-

tion of his fees. There being about a thousand insured persons per physican, the average annual income is $2250.

Those eligible to be insured are all persons 16 years of age or older employed in manual labor, whatever their earnings, and all persons of these ages in non-manual labor whose earnings do not exceed $1200. The employee and the employer contribute each 18 cents a week, and the Government adds its contribution. From the fund the insured are also provided with drugs, medical appliances and dental services. So is one common anxiety of humanity minimized by providing in the years of health against the evil days of illness. This is not a time that would be selected for initiating such a scheme here, but it would be well to make the proposed coördinated State study and so be ready to take prompt advantage of the coming better days.

THE DOCTORS CAN SAVE US FROM SOCIALIZED MEDICINE

(Editorial in the Camden Courier.)

After spending 5 years of time, and $1,000,000 in money, the Committee on Costs of Medical Care has turned the medical world topsy-turvy with controversy over its report.

Headed by that arch-conservative, Ray Lyman Wilbur, Secretary of the Interior, this committee proposed the beginning of a virtual socialization of medicine.

To that, this news-paper is unalterably opposed. We do not believe many citizens would like a medical "system" controlled by politicians. We wouldn't.

One of the first requirements in successful medical treatment is that confidence be established between physician and patient.

Under a socialized system, carried to the ultimate degree, the patient would have to take what v doctor the State sent him.

Dr. Wilbur's committee, of course, did not go that far. It proposed to advance the present system of free clinics, by expanding centralized hospital work of a gratis nature—and the physicians are up in arms because they have suffered, as it is, from competition of these clinics—which have given free medical advice not only to the poor *but to thousands of people well able to pay for medical service.*

The whole problem is complex. But there can be no overlooking the fact that while medicine has gone ahead by leaps and bounds in its scientific aspects, in its relations with the public it has maintained a code of ethics out of place in present day civilization.

We stand right with the doctors when they demand a controlling voice in the dispensing of free medical care. We believe that with them, and not with the State, must rest the control of medicine in the future, if it is to advance as it has in the past.

But the reason many physicians have found themselves in the present situation; the reason hospitals offer illness insurance based upon *free service* by the doctors—is because the ethical code of the medical profession has prevented candid relations of that profession with the public.

(It will be noticed here and in the second preceding paragraph that this mistaken idea about our code of ethics is an obsession with the Courier.—Reik.)

It is honorable for a doctor to charge a fair fee, for him to be paid by hospitals—and it is but fair that every patient should know in advance the cost of medical care he wants.

It is the duty of the medical profession, too, to solve the problem of care and hospitalization for the middle classes—indeed, to take over its own *business as well as scientific leadership.*

It must meet the challenges which have led to this report which would pave the way for socialization of the profession.

This news-paper believes that can be done with ease—if medical science will forget archaic ethics, if it will recognize that upon assumption of social responsibilities linked with its profession depends the hope of staving off government control.

This is to be remembered: that once bureaucratic medicine is fastened upon the nation, it will be as hard to get rid of as any of the bureaus which cling like leeches today.

Nation's Business, Editorial by Merle Thorp, Jan.:

The socialism of medicine is but a step toward the socialism of industry. To tax A to pay B's doctor's bill is an appealing plan, particularly when we put it on the ground of conserving public health. But why not then tax A to pay B's food bill, since it is nutrition that is essential to health? It is comforting to know that the doctors themselves are in revolt at the Wilbur report.

(4) The Reaction of the Journal of the American Medical Association:

Dec. 3: Abstract and Analysis of the Final Report of the Committee on the Costs of Medical Care, p. 1954.

Editorial: p. 1950: "The 2 reports represent the difference between incitement to revolution and a desire for gradual evolution based on analysis and study. * * * The Journal, under the auspices of the Board of Trustees, representative of organized medicine in this country, urges physicians to familiarize themselves with the Report of the Committee on the Costs of Medical Care. It urges, after careful consideration, support of the *Minority Report* signed by the representatives of the American Medical Association in the Committee. The American Medical Association, through its Board of Trustees, supports the *Minority Report.* No doubt the House of Delegates, at its session in Milwaukee next June, will urge every physician affiliated with the Association to do likewise."

Dec. 10. Another Editorial in support of the above stand.

Dec. 24. Letter from a member, attacking the *Majority Recommendations.*

Dec. 31. Letter from the General Director of the Commonwealth Fund, stating that this Fund "does not subscribe to or approve of the program of the *Majority Report* looking toward the establishment of socialized medicine".

Feb. 4. Description of a corporation organized under the title, United Medical Service, Inc., and denouncement of its purposes and advertisements.

Mar. 18. Discussion of article in March issue of The American Mercury, by H. L. Mencken, on the *Report*, p. 822.

Mar. 25. Editorial: Hospital Insurance and Medical Care, setting forth some of the dangers of hospital insurance plans now being offered to the public. Four articles: Basic Considerations in Minority Report of Committee on the Costs of Medical Care, by Alphonse M. Schwitalla, Ph.D., p. 863. Investigations and Conclusions of the Committee on the Costs of Medical Care, by Dr. Lewellys F. Barker, p. 868. Pre-Payment Plans for Hospital Care, by Dr. R. G. Leland, p. 870. Comments on the Internship, by Dr. W. C. Rappleye, p. 873.

Apr. 1. Editorial: Hospital Insurance Plans: Further comment on these plans.

(5) The reaction of the profession at large, as shown in other State Medical Society Journals, (a) through editorials, and (b) action taken or planned for the future:

(A) Editorial comment:

Alabama: "Viewed dispassionately, the point of variance in the 2 reports, while at times sharp, need not prove insuperable nor irreconcilable. Within the County Medical Societies are to be forged the weapons by which victories will be won."

Arkansas: Expressed no comment, but reproduced the Editorial in the Journal of the American Medical Association of December 3, 1932.

California: Took stand similar to that of Alabama.

Delaware: Took stand similar to that of Arkansas.

Illinois: Considered the entire *Report* a "monumental flop".

Indiana: Urged study of the report; believed that the *Majority Recommendations* would bring "much grief" to the profession; and concluded that: *"While we do not wholly agree with the Minority Report, we endorse it."*

Iowa: Considered that the *Minority Recommendations* would "more effectively" serve the needs of the public and the purpose of the profession, but: "The plan of either group is not ours to accept or reject. This prerogative lies with the American People."

Kansas: Took stand similar to that of Arkansas.

Louisiana and Mississippi, as represented in the *New Orleans Medical and Surgical Journal*: "We feel that the majority of the practitioners of medicine will be in accord with the *Minority Recommendations*. It is unfortunate, however, that the Minority Group did not have something more definite and more specific to recommend. * * * There can be no doubt that this *Report* will be read by many intelligent laymen and will be the basis of discussion and of the presentation of many schemes to alter the fundamental principles of the practice of medicine. Physicians, to combat any idealistic, unpracticable, and unworkable schemes, should be familiar with the contents of this report."

Maine: Not in favor of the *Majority Recommendations*, but gave no enthusiastic support to those of the *Minority*.

Massachusetts, New Hampshire and Vermont, as expressed in the *New England Journal of Medicine*: "Taken as a whole, the views of the *Minority*, as set forth by Dr. Van Etten, are divergent from those of the *Majority* only in degree and not so much in fact as one would be led to believe."

(Another editorial): "This *Final Report* should be studiously considered, and acted upon by the medical profession. The public seems to be insistent that something be done about existing conditions. The problem is difficult and complicated. It calls for intelligent thinking and careful, pains-taking study, rather than for emotionalism."

Missouri: Called attention to the fact that several component societies had adopted the *Minority Recommendations*.

Oklahoma: "Inclined" to favor the *Minority Recommendations*, but considered further study necessary before formulating a definite opinion.

Rhode Island: Took stand similar to that of Oklahoma.

Tennessee: Definitely favored the *Minority Recommendations*.

Wisconsin: Opposed the *Majority Recommendations*.

(B) Action taken or planned for the future:

District of Columbia: At meeting in March, the Medical Society of the District of Columbia appointed a committee of 7 "to study the entire question of the Costs of Medical Care and report to the Society its findings and recommendations".

Kentucky: The Council of the State Society held an all-day session on January 19, to discuss the *Report*. It arrived at no definite conclusion, but requested that each County Society study the subject with reference to local problems, and, if any County Society considered it necessary that the State organization take action, it should so instruct its Delegates. The statement was made that: "As far as we are able to ascertain, there is practically no physician in Kentucky who favors State Control of the practice of medicine in any way, shape or form."

King's County, New York: A special committee was appointed to consider the *Report*, and it was reported that: while it had not completed its study (March Bulletin), "it was in general accord with the *Recommendations* of the principal *Minority* group; believed that more study should be given to the various proposals; suggested that this preliminary report be sent to the Medical Society of the State of New York", and asked to be continued, "to give further study to constructive suggestions for the solution of the problems involved".

Michigan: The Executive Committee of the State Society considered the *Report*, and stated: "It is recommended that County Societies, by suitable action, record endorsement of the *Minority Report.*"

Minnesota: The President of the State Society called a meeting in December to consider the *Minority and Majority Recommendations*. Those present included physicians, and also representatives of dental and hospital associations, nurses, members of the Woman's Auxiliary, and medical students. Sixteen speakers, including Dr. E. H. Cary, President of the American Medical Association, presented both sides. No action was taken, but: "The sum total of all of the discussion successfully conveyed a picture of the conflicting opinions and problems entering into the current situation."

New Haven Medical Association: Report of a Committee on the Final Report of the Committee on the Costs of Medical Care, adopted Jan. 25, 1933. (Published in J. A. M. A., Feb. 11.) "Your committee feels that the plan offered by the *Majority* members of the Committee on the Costs of Medical Care is impracticable as a wide-spread general plan and would not result either in a lowering of the costs of medical care or in improvement in the administration of it. * * * We believe that physicians should keep themselves informed regarding changes which are going on in the relation of medicine to the public, that they should attempt

to estimate dispassionately the various bearings of different schemes proposed on the efficiency of medical service to the public and that they should take an active interest in the organization and promotion of methods for equalizing the costs of medical care and promoting the general health of the public. We believe that whatever changes take place should take place through evolution and not through revolution."

Ohio: Editorially, took no decisive stand but leaned toward *Minority Recommendations*. The Council of the State Medical Association issued a brief discussion in which some features of the *Majority Report* were approved but in which a definite stand was taken against "elaborate, expensive group practice", and in favor of the declaration of the *Minority*, that "government competition in the practice of medicine be discontinued".

Texas: The Executive Council of the State Society met, and reached the conclusion that: "The Council was of the opinion that it should not go on record as favoring any report, no matter how well and forcefully presented, which it had not been able to study." However, it passed a resolution adopting 2 paragraphs of the *Minority Recommendation*, the one opposing "corporate practice of medicine", and the one recommending trial of methods which will not interfere with the fundamentals of medical practice. It directed County Societies to appoint committees on medical economics, to read the *Report* and prepare thorough discussions, "in order that delegates may come to the next annual session with some conception of the situation and what is best to be done about it". The February issue of the State Journal gave the editorial policy as follows: "We have abstained from discussing the subject editorially from our individual viewpoint. We feel that a question so broad and deep and impressive should not be left to the decision of any individual or group of individuals, except they have been nominated by the medical profession as a whole."

Virginia: A Special Committee on Public Relations would, it was announced, consider the *Report*. An article by Dr. J. C. Flippen, President of the Medical Society of Virginia, was published, which stated that: Local medical societies, in association with local civic organizations, will be asked to suggest plans by which certain *Recommendatinos of the Majority* may be put into operation. The public will expect from the medical profession enlightened leadership and advice. Therefore: "Let us not sacrifice this extremely important strategic position. Hasty accusation of personal bias on the one hand, or of bureaucratic methods on the other, cannot be expected to re-act favorably upon a thinking public. Whatever our first impressions may be, it would certainly seem the part of wisdom to study carefully the full Committee *Report*."

Concerning Our Neighbors

Anxious to ascertain what our immediate neighbors—the States of New York and Pennsylvania—might have said or done, and treating them separately from our alphabetically arranged list of the other States, we turned to the Journals of their State Medical Societies, and to material received other-wise or from some of their officers. Our findings regarding Pennsylvania and New York will now be given.

Pennsylvania: Dr. Frank C. Hammond, Editor of the Pennsylvania Medical Journal, and Dr. Walter F. Donaldson, of Pittsburgh, Secretary of the Medical Society of the State of Pennsylvania, constitute, we think, the *strongest-team-working State Society Editor-Secretary combination* in this country. Always in the advance guard, always sane and stable, always prepared for emergency and dependable in action; they are worthy of the leadership accorded them by their associates in the field of organized medicine.

Editorially, the Pennsylvania Medical Journal of February 1933, page 345, says:

"*Medical leadership.* The public, whose opinion ultimately decides the course of our social evolution, looks to influential leadership for guidance. It is true that an imposing series of signatures to a proposal may produce immediate reactions which may out-weigh logical arguments. It is also true that the public, bewildered by statistics, may accept deductions drawn therefrom at their face value, to the exclusion of opinions expressed by those who base their statements upon practical experience and trained vision. This public is inclined to interpret expressions of righteous indignation or justified exasperation by medical leaders, as a manifestation of panic. The recent publication of the "Committee on the Costs of Medical Care" excited some unfortunate responses, which may have suggested that the medical profession was jealously guarding a prerogative to which it was not entitled. These responses, breathing antagonism to social trends, have excited such unpleasant rejoinders as to stamp the most altruistic profession in the world as being selfish. Public confidence must be based upon understanding. No group in the world has a better opportunity to educate the public by personal contact than the members of the medical profession. *Orderly thought, with manifest tolerance and a willingness to consider in detail any proposition involving social welfare as it relates to public health, will gain for us the public confidence.* We desire no special privilege, so the appellation of "union", as applied to medical organizations, is an indictment of us which we do not deserve. It breeds antagonism. It invites demagogic reprisals. *We are perfectly willing to coöperate to conserve our ideals. Let every one know this. Let us remove the heat from our utterances, and turn what threatens to be a public tragedy into an advance in the position of the practice of medicine, which will mean a contribution to public welfare.*

The County Medical Society must express to the public its earnest desire to accord opportunities at all times for frank and free discussion of sociologic problems. Unanimity of opinion is respected above all else, and it is, therefore, mandatory upon our County Societies that they express themselves coordinately. Confidence in the County Medical Society, based upon a trust in the honor of its ideals, will add toward sane social progress a most vitalizing component to the social scheme. The motives of the County Society must be understood in a true light. Tempered with tolerance and equipped with its collective experience, the Medical Society's advice and guidance will provide a leadership in solving all the public's health and sickness problems."

Plans devised for informing all the members of their Society, included: (1) Distribution of the Final Report of the Committee on Costs of Medical Care by sending a copy to each Councilor and requesting him, in coöperation with the Trustee in his District, to take such steps as might seem best

for delivering the essentials thereof to all members practicing within his domain. (2) Publishing in the Journal certain pertinent parts of the Report. (3) The construction and wide dissemination of a special *Primer* which, by adaptation of the *question and answer method*, was designed to supply the reader with answers to most of such questions as would naturally arise within himself spontaneously.

The last mentioned feature, the *Primer* (a pet method of our own which has on several previous occasions been used effectively), is unique and will, we feel sure, be productive of good results. In its preparation, the Public Relations Committee, under the Chairmanship of Ex-President William H. Mayer, of Pittsburgh, participated.

Shortly after the Report was made public, a statement was issued over the signatures of President Falkowsky and Secretary Donaldson (and the Councilor of the District into which it was to be sent), as follows:

"At the December meeting of the Board of Trustees of the Medical Society of the State of Pennsylvania, the undersigned were appointed a committee to assist in preparing a digest, with comments, of the recently published 'Report of the Committee on the Costs of Medical Care'. This we have undertaken to do; and, we have added also 2 or 3 paragraphs from the 'Final Report of the Commission on Medical Education', which we trust will serve to call your attention to that excellent report."

The *Digest* accompanying that message comprised 12 type-written pages, legal-cap length, naming and qualifying those who constituted the Committee; analyzing the *Recommendations*—of both the Majority and Minority—and commenting on each; and, commending certain points to the consideration of individual physicians. The limited space now available permits us only to illustrate this description by the following selected paragraphs.

"The Committee on the Costs of Medical Care, entirely independent of government or political control, was organized in 1927 as a result of a series of informal discussions and conferences at meetings of the American Public Health Association and the Annual Educational Conference conducted in Chicago each February by the American Association of Medical Colleges and the American Medical Association. * * *

The work of this announced fact-finding organization was financed principally by the Milbank Memorial, Julius Rosenwald, and Twentieth Century Funds; the Russell Sage, Rockefeller, New York, and Josiah Macey, Jr., Foundations; and the Carnegie Corporation.

The report as finally published gives credit to the following organizations for assistance: the American Medical and the American Dental, the National Tuberculosis and the Visiting Nurses Associations; the U. S. Public Health Service; health departments of various States, National Bureau of Economic Research, and the Metropolitan Life Insurance Company. * * *

The report when issued November 29, 1932, proved to have been divided into a Majority Report and a First Minority Report, Second Minority Report, and statements by 2 members of the Committee who refused to sign any of the reports. * * *

Attention is also called to the 500-page Report of the Commission on Medical Education recently published after prolonged study by a Commission headed by A. Lawrence Lowell, President of Harvard University. The study was directed by Willard C. Rappleye, M.D., 630 W. 168th Street, New York City. We quote the following paragraph because it suggests an important step toward providing the costs of medical care and emphasizes the need for education of the public:

"When the public is convinced of the value of proper medical care, there should be no difficulty in financing an adequate program of medical services, although it may mean curtailing to some extent the expenditures for non-essentials. The public buys what it is taught to buy, and manufacturers spend between one and two billion dollars a year in that instruction by means of advertising. The amount spent on candy is more than twice that expended on civil hospitals, and that spent for cosmetics is about twice the expenditures for nursing. The amount spent each year for tobacco alone is about twice the total gross income of all physicians. These items are cited only to indicate that the public can probably afford to pay for medical services. They were made largely by persons of moderate means for whom the cost of medical, dental, nursing and hospital services are most pressing.

Allowing for the defects in present methods there are fundamental advantages in the American form of practice which need to be strengthened. It is not necessary to substitute for the present efforts a paternalistic plan ill adapted to the philosophy of American life, but rather to encourage the evolution of a pattern which will embrace the desirable features of our present methods and the correction of their defects. * * *

We believe that all who signed the Majority Report are genuinely interested in the purposes of the study leading to the formulation of the Report. Since we as practitioners of medicine have so great advantage, from our personal experience in giving medical service, over those who observe and theorize only, it is our responsibility individually and through our organizations, to consistently direct and supply adequate medical service to all people at reasonable costs.

We must, therefore, be constructive, and to this end study the conclusions and the recommendations of the earnest, practical physicians, who have signed the First Minority Report. They recognize, as we all must recognize, that blanket recommendations will never be successfully applied to medical service, but they do offer worthwhile suggestions for study by every member and consideration by every county medical society devoting thought to the sickness service, preventive and curative, of the people of the county.

We commend prompt study and wide discussion of this subject to your county society, in *conjunction with* all other interested citizens and civic organizations.

The Majority Report has strongly intimated that County Medical Societies are too lethargic to carry out plans that may be recommended to them. What is to be our answer? It need not and can not be immediate, but the County Medical Society should lead and direct the discussion of this all important subject in every county in Pennsylvania."

The Primer. From the closing paragraphs of that document, we have space for the, perhaps, most important statements:

These questions and answers, prepared with much care, are offered as a source of authoritative information upon which readers, professional and lay alike, may form opinions regarding problems now under discussion involving the most precious asset of any people—average good health, and its preservation.

The practice of medicine is a true profession. Its traditions demand that, to the exclusion of any consideration, we must foster improved sickness service. We must protect the development of medical research, and safeguard the public against revolutionary change in the social and economic position of the medical profession. No experiment should deny to the citizen his inalienable right to

his own personal choice as to his physician. * * *

Equipped with all the necessary information, from reliable sources, the medical profession cannot deny its responsibility for leadership in solving the problems outlined in the Report of the Committee on the Costs of Medical Care. It is essential to the success of leadership that physicians, dentists, nurses, and those responsible for the management of our hospitals, possess an orderly knowledge of the fundamentals involved."

In addition to all this, the following communication was issued over the signatures of President Falkowsky, President-Elect Guthrie, Secretary Donaldson and Chairman of the Board of Trustees Buyers.

"This communication is addressed to you as a member of the Medical Society of the State of Pennsylvania and also as a Fellow of the American College of Physicians or the American College of Surgeons. It is intended to be explanatory of and supplementary to the enclosed *Resolution.*

At the December 1932 meeting of our Board of Trustees, at which the *Resolution* was adopted, 10 of those present were Fellows of one or the other of the above-named national organizations. Most interested physicians are, at the present time, apparently of one mind regarding the danger to the public in deterioration of the quality of the sickness service now being rendered in this country as involved in threats of the socialization of medical practice. It is believed, therefore, that we should as far as possible be heard nationally on economic subjects only through the American Medical Association.

To the end that this intent of the resolution may be accomplished, we solicit your influence with the College of which you are a Fellow.

Whereas, there have been formed important national organizations of physicians, specialists, other than the American Medical Association, and

Whereas, such organizations fundamentally formed for scientific purposes have from time to time publicly expressed opinions concerning the entire practice of medicine, especially in its social and economic relationships, and

Whereas, an unusual emphasis on the social and economic position of medical practice has recently been precipitated by the published *Report* of the national Committee known as the Committee on the Costs of Medical Care,

Be it resolved, that in the interest of the welfare of the public and the maintenance of the most serviceable form of medical practice, the proper representatives of the American Medical Association request other national medical organizations, whose qualifications for membership include membership in the American Medical Association, to publicly declare their opinions on general social, legislative, and economic relationships of medical practice only through approved channels of the American Medical Association.

To this end the Board of Trustees of the Medical Society of the State of Pennsylvania pledges its own efforts and influences to bring about this most desirable point of view in the minds of the members of the Medical Society of the State of Pennsylvania, who are also members or Fellows of the other organizations referred to. They also respectfully request the Board of Trustees of the American Medical Association to bend every effort to accomplish this purpose throughout the Association at the earliest possible moment, in order that the sane evolutionary progress of medical practice may not be disturbed by social experiments which endanger the health and the welfare of our citizenship, and which have proved a pernicious health influence in other nations.

This *Resolution and accompanying letter* was addressed to the 740 members of our State Society who are also Fellows of the American College of Surgeons or the American College of Physicians. Secretary West reports that the Board of Trustees of the American Medical Association adopted a motion expressing the most thorough sympathy with the resolution and the hope that other constituent associations will take similar action.

Dr. Hammond, editorially (Penn. Med. Jour., Mar., 1933, p. 448) directing the attention of his State Society Members to the Tristate Conference, said:

In this number of the Journal appears the report of the Tristate Medical Conference held at Atlantic City, N. J., Dec. 10, 1932. The program was specially arranged to explain the question of *National Health Insurance,* the so-called *State Medicine,* as it has developed in England since 1911, with its various modifications and amendments; and also as it has come into some of the provinces of Canada. There was also arranged a résumé of the Final Report of the Committee on the Costs of Medical Care.

The report of the conference affords very valuable instruction for our members, *all of whom are urged to read it.* Our members should know something about the experiences of other countries.

It is of interest to know that the British Medical Association recently submitted to the Government a proposal to extend the British Health Insurance Act, with slight modifications, to embrace the entire populace and to cover medical practice in all its varied aspects; among other things to include preventive medicine, treatment by specialists, and hospitalization.

In one of the papers is stressed the fact that when physicians go into conference with governmental agencies, it is necessary not only to have all the doctors united, and 100% back of the project, but in addition educated to the true sense of their responsibilities and their duties; these are facts that our officers and other leaders must bear in mind. If there was ever a time in the English speaking world when organized medicine had a job on its hands it is now, and are we organized? What is the organized medical profession? Whom does it represent in your home area? This is the time when medicine must be organized. The problem cannot be solved by differences of opinion. The question too of the open and closed hospital is something for us to think about.

As stated in another paper, the existing state of affairs in this country can be adjusted *if we approach it in the proper manner.* If we do not, *it will be maladjusted.* The *approach* is the crux of the situation. We desire our members not to become unduly alarmed; not to make utterances that will foment public reprisal, by antagonism. We must have the coöperation of the public. To secure this we must be properly instructed in all phases of the problems, that: (1) we may enlighten the people and secure their support; and (2), be better prepared to coöperate with the officers of our County, State, and National Medical Societies. As the officers of our County Societies change so frequently, is another reason why all members should be well informed, in order that, as newly elected officers, they can intelligently carry on. We should be careful not to give to the news-papers cause for adverse comment and criticism, that will unnecessarily arouse the wrath of the public against our best efforts for their interests. Much of the present "tempest in a teapot", has been caused by news-paper distortion, in both the news and editorial columns.

New York: Editorially, the New York State Journal of Medicine (Jan. 1, 1933, p. 25) under the title of "The Quality of Medical Care", says: The final report of the Committee on the Costs of Medical Care might well have rested upon a résumé of the studies in which are assembled masses of data which will be invaluable to students of public and private medical service in future efforts to advance the health status of the people of the United States.

The factual accumulation is ample justification for the existence of this Committee. The medical profession—the efficiency engineers—the social experts and the faculties will each interpret the findings differently and will be inspired to attempt experiments which will carry the colors of their traditional thinking.

Socialized medicine, mass medicine, contract medicine, commercialized medicine and governmental medicine are vividly painted in the *Report* as solutions for difficulties of medical care to all of us who have annual incomes below $1200.

Idealistic programs are indicated which seem to promise *quantity* of service rather than *quality* of service; and while also claiming to protect the personal relationships between physician and patient, carry no conviction to the practicing physician whose practical experience with our present large hospital groups tells him that new privileges are not for him.

It is natural that there is no promise to lessen the national health bill, and there cannot be if adequate service is delivered based upon our present knowledge of the cost of delivery.

The bill promises to be larger without improving the income position of the physician. The arguments for voluntary insurance schemes, immediately followed by elaborate statements that all voluntary insurance is futile and invariably leads to required insurance after the European manner, is disheartening to those whose experience with provident insurance leads them to think that insurance budgeting for future catastrophe or the decadence of age promises security and is capable of extensive application.

The proposal of per capita contract schemes for serving large groups of individuals under the aegis of all sorts of direction, with no guaranty of the *quality* of medical care or the character of personnel, also seems to lead to inferior service to the sick and to inevitable governmental control.

Proposals for better community service originating in and carried on by County Medical Societies receive scant attention in the *Report*, the authors of which seem to be satisfied that their opinion is of a superior fabric to that which binds together the 100,000 members of the American Medical Association who live with these problems and are daily trying to improve the quality of medical care.

After the first chapter, the *Report* staggers through 107 pages of idealistic and materialistic suggestions of programs, with frequent genuflection and finally prostrate obeisance to compulsory health insurance. In the last chapter some clearer headed writer almost entirely divests himself of nebulas and issues a "challenge of the future" which is a splendid call to the best that is in our medical ambition.

The Minority Report seems to be based on the practical experience of its authors, who cannot be diverted from the realities of their investment in the practice of humanity into speculative fields which might imperil the quality of their service. The *Minority* is neither satisfied with things as they are, nor smugly complacent in thinking that things cannot be improved. They see the evolution of medical service as a slow process, but believe that it will meet changing social currents warmly and sympathetically.

The *Minority* believes that experiments with new forms of service should originate in the County Medical Units and be tried there; and that all physicians should be enlisted under one ideal which should be the delivery of the best service of scientific medicine possible, in all its forms, to all of the people.

(6) Reaction of Component Branches of the Medical Society of New Jersey, as shown by reports of their meetings, published in the February and March Journals:

Atlantic. December meeting: Dr. W. Blair Stewart called attention to the Report, and the editorial regarding it, in the J. A. M. A. for December 3, saying that "every member of the medical profession should take time to study that *Report* carefully". Dr. Scanlan said: "Every member of the Society should be acutely interested in studying the *Report* so that when the time comes to protest or approve the *Recommendations*, each member will be fully familiar with the situation. I believe that the general medical practitioner is going to be pushed out by big medical centers and we seem to be headed toward *state medicine*." Dr. John Bennett Morrison, present as a guest, also spoke regarding the *Report*, stating that every man in the medical profession should spend the time necessary to study the report thoroughly, and the County Society should take some definite stand regarding this matter.

Bergen. January meeting: Dr. Samuel Alexander, in accepting the presidency, made a "plea that the Society dedicate itself for the next year to improving the physician's economic status and giving serious thought to the *Reports* from the National Committee".

February meeting: Dr. David Kaliski, Retiring President of the New York County Medical Society, a guest, presented a paper on "The Present-Day Status of the Medical Economic Question", with special reference to the *Report*. Dr. Samuel Kopetzky, Editor of the New York Medical Week and a Past-President of the same society, spoke on "Group and Contract Practice". Discussion was opened by Dr. John Bennett Morrison, another guest. The Executive Secretary, Dr. Henry O. Reik, explained his object in collecting and editing material bearing on the *Report* for the January Journal.

Burlington: A special meeting was held on Feb. 2 to discuss the *Report*, with the object, as stated by Dr. John Conroy, presiding officer, "not to vote one way or the other on it, but to bring certain facts to our attention". Drs. A. C. Morgan, a signer of the *Minority Report*, Hyman I. Goldstein, J. Bennett Morrison, Ephraim Mulford and F. E. Proctor, and Mr. Heffinger (Superintendent of the Mercer Hospital), discussed the subject at length (pp. 283-4-5-6-7-8-9, March Journal). A committee, composed of Drs. E. R. Mulford, Emlen Stokes, Daniel Remer and R. I. Downs, was appointed to study the question further and report later to the County Society.

(A Special Bulletin, announcing this meeting, stated: "Concerning the *Minority Report*, it seems to fit in better with the present-day attitude of the profession; on the other hand, the public and the profession must realize that some changes are imminent. * * * Please be mindful that hasty action—decisions made without having previously studied all the available knowledge—conclusions based upon prejudices—these are the things which

the medical profession has most need to fear at present.")

Camden. December meeting: It was decided that a Special Committee study the *Report* and present their results to the Society at its next meeting.

January meeting: Dr. A. C. Morgan, invited to set forth his views as a signer of the *Minority Report,* "spoke with enthusiasm for retention of the family physician as the key to successful medical economics". His talk was discussed by Drs. T. K. Lewis, Hyman Goldstein, J. S. Shipman and Alexander Macalister. "Dr. William Shafer moved that a Committee be appointed by the President to study the *Report,* and present at each meeting hereafter the results of its findings." This motion was passed unanimously, and a committee appointed, composed of Drs. T. K. Lewis, George P. Meyer, David Bentley, Jr., A. L. Stone, W. J. Barrett, B. F. Buzby and H. F. Schrack.

March meeting: Committee reported as "functioning and gathering data".

Essex: A hospital insurance plan in operation in Essex County was explained by the Reporter in the Feb. Journal, p. 186-7. While this does not, strictly speaking, belong under the heading for this section, it is mentioned because it bears on the present economic problem.

First Councilor District Meeting (Essex, Morris Union and Warren): Dr. N. B. Van Etten read a paper analyzing the *Report* (to be published later in the Journal). Drs. F. J. Quigley and J. Bennett Morrison discussed the paper, but the discussion has not been reported to the Journal.

Gloucester. January meeting: A Special Committee was named to investigate the *Report,* and report findings at the next meeting—Drs. W. J. Burkett, R. K. Hollinshed, J. Harris Underwood, C. I. Ulmer and H. M. Fooder.

February meeting: The committee reported progress.

March meeting: Dr. Burkett presented report of committee. Ordered to be mimeographed and distributed to all members.

Hudson. December meeting: The President appointed a special committee of 15 to study the report.

Mercer: March meeting devoted to consideration of a report of a special committee which had been appointed to study the Wilbur Committee *Report.* After discussion, the Society adopted the *Minority Report.*

Middlesex. Meeting Nov. 30: The Secretary read a letter on the Costs of Medical Care. Action was delayed until the full *Report* should be available.

Monmouth. Meeting Nov. 30: There was some discussion of the *Report,* but a fuller presentation was delayed until the next meeting.

Meeting Dec. 14: Dr. Stanley Nichols discussed the *Report.* "He deplored the *Majority Report,* and pointed out definite objections to the schemes proposed; endorsed the *Minority Report,* and urged the Society to assume the responsibility for leadership in solving the problems presented by the need of adequate health service for all."

Passaic. December meeting: Dr. Marsh's motion, "that a committee of 5 to 9 members be appointed to study the *Report",* was adopted.

Somerset. Meeting Feb. 9: A letter from President Lippincott was read, suggesting appointment of a committee to study the *Report.* "Discussion followed, and it was pointed out that the Economic Number of the State Journal carried a comprehensive account of this *Report* and that no special committee was necessary. It was then voted that the Secretary write the President and inform him that this County Society is unanimously in favor of and endorses the *Minority Report,* having adopted the following resolutions: (1) The members of this Society are acquainted with the *Report,* and (2) the Society unanimously *endorses the Minority Report.*"

Sussex. Meeting Dec. 15: A letter from the Committee on Costs of Medical Care was read and referred to the County Welfare Committee.

Union: A special meeting was held on Feb. 15 to discuss the *Report.* Special speakers were Dr. Henry O. Reik, J. Bennett Morrison, and Archibald Sinson, now of New York, but formerly of Elizabeth. After lengthy discussion, the chair was instructed "to add 2 members to the County Society Welfare Committee, which was instructed to carefully consider this important subject from all angles, and to be prepared to make a full report to the Society at its next meeting. This rather lengthy meeting was marked by the close attention given to speakers, by the large audience, and, further, by the fact that discussion was carried on mainly by our own members. * * * At similar county meetings held elsewhere, most of the talking has been done by one or more invited guests, often by members of the Committee, and in consequence, a full expression of opinion has not been gotten from those most concerned, especially the younger men, as to what position shall be taken by the State Society."

(7) Miscellaneous items bearing upon this problem:

RELATION OF PHARMACISTS TO THE COSTS OF MEDICAL CARE

Robert P. Fischelis

(An Abstract, prepared by the Editor, of an Address delivered by Mr. Fischelis at the Toronto meeting of the American Pharmaceutical Association, August 24, 1932.)

The practice of pharmacy in its various subdivisions has recently been subjected to a series of fact-finding surveys calculated to establish the need and importance of certain of its services to the public, as well as the efficiency with which those services are rendered and the adequacy of the compensation to the personnel engaged in rendering those services.

One need only mention the various State and regional surveys of prescription practice, the studies on the range of ingredients of prescriptions, the individual commercial studies of the St. Louis Survey conducted by the Department of Commerce and the recently completed study of the manufacture and distribution of drugs and medicines in the United States under the auspices of the Committee on the Costs of Medical Care, to call to mind the extent and far-reaching character of these undertakings.

While the busy pharmacist in his shop is apt to concentrate attention upon the practical aspects of these fact-finding studies and lose pa-

tience with the consideration of anything that does not seem to point the way to immediate improvement in his financial situation, the leaders in the profession must take the long view and endeavor to discover in the mass of data accumulated, the trends in pharmaceutic practice on which to base policies for the future development of pharmacy along sane and logical lines.

No careful student of all of these surveys can escape the conclusion that the future of the practice of pharmacy is closely interwoven with the future of the practice of medicine. Pharmacy, in its strictly professional aspects, is a specialized form of medical service. The practice of medicine is an art which utilizes the sciences. It is also an economic activity with definite relations to the cost of living, the distribution of wealth and the purchasing habits of people. About one and one-half million American citizens, including about 120,000 pharmacists, make their living in this broad field and for their services the American people pay annually more than $3,500,000,000.

In recent years, "big business" has been absorbing and assimilating as rapidly as possible the profit-producing features of the Practice of Pharmacy. Witness, for example, the virtually complete control of all popular proprietary medicines that can lay claim to any therapeutic value by a few financial groups; the gradually increasing control of all important wholesale and retail outlets by the same or similar financial groups; the gradual control of the popular lines of drug products, cosmetics, confectionery and other side lines in so-called independent drug stores by the same or similar financial groups. Witness further the gradual divorce between the power of control and knowledge which Mr. Justice Holmes, in his dissenting opinion in the Pennsylvania ownership law case, properly characterized as an evil. We have seen the passing of control of many of our manufacturing pharmaceutical houses from the hands of the pharmacists who organized them, and as pharmacists could be expected to frown on unprofessional practices, to the hands of financiers motivated solely by the instinct for profits. To them: medicine is merchandise; drugs are to be *sold;* and, the methods of sale are the high-pressure methods of big business. What does it matter whether the health of the nation is good and the public demand for drugs is below normal? We must overcome this sales resistance just as we overcome resistance to the sale of bonds, or lumber, or cigarets.

Here we have the parting of the ways between professional pharmacy as a specialized form of medical service and the drug business. The need for the services of professional pharmacists is predicated primarily upon the need of properly prepared medicines ordered by a physician to meet an individual illness. Legally, at least, his services are not required to dispense non-poisonous patent or proprietary medicines. When pharmacists advocate close adherence to orthodox medical practice they may be accused of being more interested in their own welfare than in the common good. It is, therefore, gratifying that a disinterested group of such high standing as the Committee on the Costs of Medical Care, after careful investigation of the facts, has come to certain conclusions which strongly *emphasize the importance of the practice of professional pharmacy by pharmacists.*

They have made 4 recommendations based on these conclusions, which, if carried out, would go far toward reëstablishing professional pharmacy upon a firm foundation. These recommendations are as follows:

(1) More adequate use should be made of the professional knowledge and skill of pharmacists by such methods as: (a) increasing the opportunities for prescription compounding through elimination of the prescribing of branded products by physicians; (b) permitting the instruction of drug-store customers in the proper use of medicines which are purchased for self-medication, but not to the extent of diagnosing patients' ailments or recommending medicines based upon description of symptoms; (c) arranging for the distribution by the pharmacist of general health information prepared by health departments, both with regard to medicines and general matters of hygiene; (d) arranging for the distribution of information to the public concerning the availability of physicians and hospitals, on the basis of lists of physicians provided by local medical or hospital associations.

(2) Agencies should be established to prepare and disseminate accurate information concerning the proper use of selected lists of "home remedies" appropriate for self-medication. The lists should be established by a committee of physicians and pharmacists of unquestioned reputation and standing; the distribution of the literature may be accomplished by health departments, hospitals, drug-stores, or appropriate lay associations. Universal and unnecessary use of home remedies, "patent medicines", and other self-prescribed medicine should be vigorously discouraged.

(3) Secret-formula drugs and medicines should be abolished through the compulsory disclosure on the label of the kind and quantity of medicinal ingredients. Individuals or enterprises which have developed new and distinct preparations should be financially pro-

tected by appropriate privileges granted by the United States Patent Office or by a disinterested agency established for the purpose.

(4) All manufacture of drugs and medicines, regardless of class or kind, should be required to operate under annual licenses to be granted by the Federal Government upon the fulfillment of satisfactory conditions with regard to competency of personnel, equipment and sanitary surroundings, and standardization of finished products.

Pharmacists have been urged at various times to *become politically-minded* in order to conserve their rights and privileges. It would seem that *the real need of the moment is to remain professionally-minded* and as rapidly as possible to become inter-professionally-minded for it is certain that professional pharmacy cannot progress independently of medicine and the other health professions.

ANALYSIS AND COMMENT ON SOME PHASES OF THE FINAL REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

Herbert E. Phillips, D.D.S.,
and
C. E. Rudolph, D.D.S.

(As the article by Mr. Fischelis spoke for the Pharmacists this paper speaks for the Dentists.—Ed.)

After 5 years' study by the Committee, it might seem that the primary result was the formation of 2 camps of zealots ready to rend each other limb from limb, if necessary, to secure good medical care for the American people. We hasten to take sides, but, not being completely Irish, pause first to ask: What is the point at issue? Does the Report threaten the stability of organized medicine? Does the Minority Report connote a break by the profession from the needs or desires of the public? Let us examine the actual or presumed causes of quarrel before we do take sides in this Donnybrook fair.

There were 48 members of the Committee, 25 of them with the medical degree. After 5 years' association, these 25 physicians, all members of the American Medical Association, disagreed.

In an editorial in the *Journal of the American Medical Association* of December 3, 1932, the Editor, interpreting and endorsing the Minority Report, and discussing and decrying the Majority Report, said: "The alignment is clear—on the one side forces representing the great Foundations, public health officialdom, social theory—even socialism and communism —inciting to revolution; on the other side, the organized medical profession of this country urging an orderly evolution guided by controlled experimentation." On the one side, 17 physicians and most, though not all, of the lay members of the Committee; on the other, 8 physicians and 1 layman. The effect of this editorial was to make it appear that there existed a fundamental cleavage within the profession.

The Editor of the *Journal of the American Dental Association* evidently shares the attitude of the Editor of the *Journal of the American Medical Association,* for in an editorial of January 1, he writes: "The expenditure by the Committee of nearly $1,000,000 might have had some justification if there had not been at the outset of its activities an evident bias in favor of ideas that were subversive of the best interests of the professions and of ultimate harm to the public. The views of state medicine and state dentistry and socialistic clap-trap of all kinds manifested its presence at the beginning. And every argument was used to bolster up the theory of governmental paternalism as it related to the professions. * * * The issue is clear-cut and we stand traitors to the trust reposed in us * * * by the pioneers of our profession * * * if we yield our prerogative in the slightest degree to the machinations of those who would sell us out and debauch our profession." The Editor also prints the American Medical Association editorial in full and recommends its reading by dentists.

According to the editorial in the *Journal of the American Medical Association,* 17 *medical* "socialist communists" signed the Majority Report; 8 *medical* "orderly evolutionists" signed the Minority Report. Did these physicians divide on principles clear-cut and basic or did they agree on principles and divide merely on detail? Let us stand our shillalahs in the corner while we examine their attitudes on some of the important phases of the *Report.* We believe we can lose our grip on our own shillalahs easily, for, as members of the Committee, we signed a statement separate from both the *Majority* and *Minority Reports.*

On one major point was there a sharp difference of opinion between the majority and minority, namely, the desirability of developing comprehensive *medical centers* in each community. The minority condemned this proposal as being far-fetched and visionary, and as smacking of "big business" and large scale production.

A less clear-cut division occurred over the question of *compulsory health insurance.* Neither majority nor minority report recommended compulsory health insurance, but 2

physicians from each group signed an independent statement advocating this procedure. The minority group preferred compulsory to voluntary insurance; whereas, the majority report recommended trial and development of voluntary health insurance plans.

On general principles, the use of sickness insurance for medical care was rejected by both the majority and minority groups. The majority urged the general extension of voluntary coöperative health insurance; whereas, the minority would approve this type of insurance only under the auspices of local medical societies.

Both groups advocate group practice, although they recognize the limitations of such service in maintenance of professional standards and the personal relationship. The minority offered an extensive criticism of group practice, and would have it develop only under special conditions and where needed.

Both agree on government payment for medical care of indigents, extension of public health, progress in medical education and the formation of coördinating bodies of practitioners and the public. One recommendation made by the majority, quoted and endorsed by the minority, was that *private commercial insurance should have no place in medical care.*

Both groups explicitly stated their approval of the principles that medical care is essentially a personal service; that the personal relationship between physician and patient must be preserved; and that the general practitioner should be the central factor in medical care. The differences are only as to the detail of carrying out these principles.

"Communists and socialists"—"orderly evolutionists?" We fail to distinguish them from each other, by any study of the positions of the majority and minority reports on concrete issues. "The medical center?" The minority refer to it as suggestive of great mergers in industry, of the technic of big business, of mass production. These terms connote a capitalistic factory system, not "sovietism". "Compulsory health insurance?" Recommended by 2 minority and 2 majority physicians and 7 minority physicians prefer compulsory to voluntary insurance. "Tax payment for indigents?" This is agreed to by both. "Group practice?" Agreed to, in part, by both. "Commercial insurance carriers?" They have no place in medical care, say all groups.

In the light of the above analysis, *are these physicians really far apart,* and *was the Editor warranted in assuming them to be split into 2 widely divergent groups?* Is there any ground for an issue between *revolution* and *orderly evolution?*

On December 10, 1932, the editorial columns of the *Journal of the American Medical Association* refer to the Report of the Commission on Medical Education, financed in part by some of the "Great Foundations". The editorial describes the personnel of the Commission, saying "it included for the most part distinguished medical and other educators and also representatives of the Association of American Medical Colleges and of the American Medical Association. * * * From its survey of the situation it has developed a report which is especially significant at a time when the Committee on the Costs of Medical Care has offered to the American people a series of conclusions leading toward the socialization of medical practice."

The Commission Report refers to some of the questions discussed by the Committee on the Costs of Medical Care. On the subject of group practice the report of the Commission says: *"When properly conducted group practice can provide at less cost * * * to the patient a quality of medical service superior in some respects to that provided by the general practitioner."* With regard to health insurance the Commission's report states: "The burden of illness falls unevenly. * * * It can only be met satisfactorily through the collective provision for medical care. * * * The distribution * * * can be provided through *insurance* and taxation. * * * The current trends of sickness insurance are *toward compulsory* * * * *instead of voluntary.* * * * The factors which forced the development of sickness insurance in most countries are also operating in this country."

Does the Editor of the *Journal of the American Medical Association* regard *Dr. Ray Lyman Wilbur* and *Dr. Olin West* as "distinguished educators" when they comment favorably on group practice, health insurance, and taxation, when members of the Commission on Medical Education; and divide them as "communist" and "evolutionist" when the analysis indicates they agree in principle on these same points, as members of the Committee on the Costs of Medical Care? Or did the Editor merely decide to satisfy the proclivity of the "news-paper boys" for "soviet" news?

On other points, was the minority report correctly interpreted? The minority report presents a formulation of the principles under which health insurance should develop, and rejects commercial insurance systems. Why does the editorial fail to reflect the opposition of the minority report toward commercial carriers? Why is no reference made to the splendid efforts of the Milwaukee County Medical Society or the California State Society to develop experimental insurance plans that meet

the requirements of the principles set forth in the *Minority Report?*

The *Minority Report* quotes with approval from Simons and Sinai's book "The Way of Health Insurance", where the authors say: "Study of many insurance systems seems to justify the conclusion that evils of insurance decrease in proportion to the degree that responsibilities with accompanying powers and duties are entrusted to the medical profession." (P. 167.) Almost the same words were incorporated in the report of the Commission on Medical Education which reads as follows on page 46: "Experience elsewhere has shown that the quality of medical service is directly related to the degree of responsibility placed upon the medical profession in the administration of sickness insurance." The Milwaukee County Medical Society plan places responsibility on the professions. The California plan does likewise.

The Editor offers his interpretation of the *Minority Report* and also states that "the Journal under the auspices of the Trustees of the American Medical Association urges, after careful consideration, support of the *Minority Report.*" The question naturally arises—do the Trustees support the editorial interpretation in which the members of the American Medical Association on the Committee are aligned in hostile groups, or do they support the position actually taken by the minority, as indicated by the signed statement of the *Report?*

As may be observed from the tabular comparison of the various reports accompanying this article (we sincerely regret the impossibility of reproducing here the Chart referred to; for, it is a valuable contribution to the study of this problem—Reik) the editorial interpretation is strangely out of line and at direct variance with all physician members on several important points. The most important difference relates to commercial insurance carriers.

The Editor of the American Medical Association Journal recommends the extension of private commercial profit-taking voluntary *cash-benefit* insurance schemes as a method of payment for medical care. He says: "No doubt, insurance companies could sell such policies most reasonably if a sufficient number of persons could be induced to insure themselves in this manner. Such a procedure is foresighted, American, economical." As pointed out in the report of the Commission on Medical Education, "cash benefit" insurance later shifts to "benefits in kind". "Benefits in kind" mean medical and dental care furnished by the insurance carrier. Thus "cash benefit" insurance purchased by groups, as implied in the editorial, would set the pattern for commercial control of later developments of "benefits in kind". This position is rather puzzling in an editorial promoting the *Minority Report,* since the minority statement opposed commercial agencies in medical care, and furthermore outlines very explicitly the safeguards that must surround every health insurance scheme. These safeguards demand non-profit plans and County Society control of all health insurance in order to maintain quality of service and to eliminate competition for fees. The *Report,* on pages 95-96 states that: *"Cash benefit* insurance, even when purchased on a group basis, has usually been too expensive to be of widespread importance."

Can it be that the Editor of the Journal of the American Medical Association would encourage still more competition from commercial carriers for the already harassed State and County Societies which are attempting at this time to develop insurance plans under professional auspices? The endorsement of commercial insurance and the invitation to extend it further into insurance for sickness, should be worth much to the companies seeking to enter this field on a *"cash-benefit"* basis. Is the Editor petting the tiger?

We again raise the serious question as to whether the interpretation of the *Minority Report,* as evidenced by the editorial, really represents principles endorsed by the Board of Trustees of the American Medical Association. Can it be possible that the numerous flirtations of private insurance companies with the Trustees and Officers are being encouraged? Would this explain the endorsement of commercial insurance and the neglect of State and County Medical Society non-profit plans?

The *Minority Report* presents a formulation of the principles under which health insurance should develop. *The writers of this article,* signers of the Minority No. 2 report, *are firmly convinced that this outline of principles is one of the most important pronouncements ever made by a medical group in relation to sickness insurance.* We are also firmly convinced that the development of insurance plans by the Council of the Milwaukee County Medical Society and the California State Medical Society are the most significant experiments proposed to put in practice the principles as outlined. Failure to give this minority recommendation publicity among the medical and dental professions is surely in the interest of the insurance carriers. Profit schemes of health insurance go hand-in-hand with commercialization of the professions.

The *Minority Report* represents an honest effort on the part of a minority of the physicians on the Committee to defend and explain their professional viewpoints and to recom-

mend certain plans for medical care. The *Majority of physicians* on the Committee *also expressed themselves honestly* in giving their views in the *Report*.

The physicians and dentists signing the majority and minority reports of the Committee on the Costs of Medical Care, as well as those who were members of the Commission on Medical Education, appear to agree on fundamental principles, from which the Editor of the Journal of the American Medical Association apparently sharply differs. To encourage warfare in the ranks of medicine or dentistry is to create just the condition that would paralyze the efforts of those States that are now attempting to meet their problems, and would leave an open door for commercial agencies. Public and professional coöperation are necessary to meet the tremendous problems disclosed by the studies of the Committee on the Costs of Medical Care and the Commission on Medical Education. In the writers' opinion, the *Minority Report, as printed* (not as interpreted in the editorial) *is in conflict neither with the Majority of the physicians on the Committee, the Report of the Commission, nor with the lay groups interested in problems of medical care.*

American Medicine, of January: "Organized medicine will not accept the *Report* without remonstrance. The public will accept it as a valuable contribution to the philosophy of altering medical practice, and will endeavor to secure its practical realization. * * * Physicians, in considering the merits of the *Report,* should bear in mind that unless they carefully weigh and constructively analyze both the *Majority* and the *Minority* reports, they may find themselves in a position of danger if some program is set up while they are silent—or despite their opposition. The *Report* should be read by individual physicians, and should be the subject of thorough study by County Medical Societies."

Good Health, Jan.: "Unquestionably there are grave evils in the methods of medical practice now in vogue in this country which must be corrected. Of course, the profession itself should correct the evils, which are clearly recognized, and some progress has been made in doing so; but the problem is too big to be solved even by the organized profession. Some form of State or Federal control and regulation is needed, and doubtless will in due time be evolved."

ADDRESS AT THE ADVISORY COUNCIL DINNER-MEETING OF THE MILBANK MEMORIAL FUND, MARCH 16, 1933

George F. McCleary, M.D., of England

"I find myself in this country at a time when questions of the provision of medical care for the poorer people are exciting great public interest, and I attribute that stirring of public interest in no small degree to the issuance of a dynamic document, the 'Report of the Committee on the Costs of Medical Care'. That document has been my daily reading since I received a copy of it upon landing in San Francisco nearly a month ago, and *I am much impressed by the wealth of information which forms the basis of that report.* Reading it, I cannot help turning my mind back 25 years to a time when, in England, there was a similar stirring of public interest which also depended upon the issue of a dynamic document, the 'Report of the Royal Commission on the Poor', in 1908. That report, like the Report of the Committee on the Costs of Medical Care, consisted of a majority and a minority report—both agreeing that the provision made for medical service to poor people was unsatisfactory and that something ought to be done about it. The majority recommended establishment of a huge system of provident dispensaries. The minority recommended a great extension of public health work. The government adopted neither recommendation but introduced a scheme of compulsory health insurance based on the scheme Prince Bismarck introduced in Germany in 1884.

This scheme of National Health Insurance came into operation 20 years ago, in 1912, following its adoption by Parliament, in 1911. I became at that time the Principal Medical Officer of the governmental department set up to administer it.

The medical arrangements in our scheme rest upon 2 basic principles: (1) That private insurance medical practice shall resemble private medical practice as far as possible; (2) that the scheme shall provide each insured person with the services of a family physician.

Now, I am told that the old idea of the family physician is an old-fashioned idea, which, in the light of modern advancement and intelligence and knowledge, has gone by the board. Well, all I can say is that, in England, which is an old-fashioned country after all, we do still cherish this old-fashioned idea—that it is a good thing for any patient to have, as the basis of his medical treatment, the advice of a family physician.

Now, *those are the 2 basic principles on which our scheme is based,* and to give them effect, 2 other principles were put into operation: (1) that every physician has the right to undertake the medical treatment of the insured; and (2) that every insured person shall have free choice of his physician from among those physicians who have elected to take part in the service. The question has been put to me—what is the effect of the English scheme of National Health Insurance upon the quality of medical service given? Before I answer that question, I would ask—how is the quality

of medical service kept up to the mark in private medical practice?

Well, there are various circumstances which keep the physician up to the mark. In the first place, a physician is placed every day and every hour of his daily life, in contact with suffering people, *and the natural reaction of any person placed in such a position is to do what he can to relieve suffering;* and particularly if he is in possession of special knowledge which he may apply to that end. Secondly, the physician is essentially a craftsman. He has spent many years in obtaining facility in a highly skilled and difficult art, and *he has in the exercise of his art the joy of creative effort.* Your President, in his wonderful Inaugural Address, said: "The most satisfactory thing in life is creative effort." The physician's work is creative effort; and it is given to him, as it is given to a few other men, to create a healthy person. Then, there is the economic motive. After all, the physician who does his best for his patients, and obtains results, naturally will get a larger cliéntèle. We all know, of course, that there are charlatans in the medical profession, as there are in every profession, and they, too, can amass a considerable number of patients; but, in the long run, and on the whole, the successful practitioner is the one who does his job in the most competent way.

There are 3 influences tending to make for efficiency in private practice. How are those influences at all damaged under our scheme in England? Why should the insurance practitioner, simply because he has accepted service under a great national scheme having for its object the improvement of the health of the nation; why should he, placed in contact with a suffering (insured) patient, suddenly become calloused and regardless of his responsibilities? Why should he lose the skill, the joy of the successful craftsman? I see no reason whatever, and, *in fact,* it does not happen.

One effect of the insurance scheme has been to create in every insurance area and county borough a committee of physicians, the 'Local Medical Committee', a committee charged with definite public responsibilities. The formation of such committees, and their operation, has had the effect of developing a collective professional conscience in the various areas. Those committees are called upon to exercise certain supervisory, indirect supervisory, functions in relation to the practitioners of the area; and we find that they approach their public work in no spirit of narrow professionalism, but with due regard to the important public responsibilities which devolve upon them. The creation of those committees has had, in the opinion of those who are best fitted to judge, an important effect in tending to raise the general level of efficiency of the insurance physicians.

Then again, we have what we might call the *disciplinary procedure.* We have 15,000 Insurance Physicians (Panel Doctors) in England and Wales, and we have 15,000,000 insured persons. Now, whenever you get 15,000 persons, in any rank of life, you will have some whose conduct and efficiency fall below that of the standard which should obtain throughout the profession; therefore, it is necessary to give the insured person some way of expressing any feeling of grievance he may have against his physician. He has a right to complain, and if he does complain, his complaint is heard by a local committee consisting of an equal number of physicians and representatives of insured persons.

The number of complaints every year is very small, about 250, and in the majority of cases it is found that the complaint has no substantial foundation. The committee hearing the complaint, as I have told you, is a committee partly consisting of physicians, and that leads me to my last remark, which is, that in our scheme the medical profession plays a very prominent part in the administration, and particularly with that part concerned with hearing complaints against insurance physicians. I, myself, have taken a great part in this, what we call disciplinary work, and have sat on many tribunals with colleagues from outside, and I find, as we all find, that in respect to outside physicians engaged in this work taking a lenient and narrow professional view of the conduct of their erring brethren, precisely the contrary is the case. So that I have often thought that if I myself had to answer an allegation which had some suspicion behind it, I would far rather have my case heard by a lay tribunal than by one consisting of members of my own profession.

I have endeavored to indicate to you in what way the quality of medical service is maintained under our scheme, and *I can say from my own personal experience, which coincides with that publicly expressed by the British Medical Association, that our insurance scheme, so far from having degraded, as is sometimes stated, the standard of general medical practice in Great Britain, has, on the contrary, had a great effect in improving it."*

To judge from the newspaper account of the dinner of the House of Delegates of the New York State Medical Society on April 3, appearing as we go to press, Dr. McCleary delivered a speech, similar to this, as a guest at that dinner.

Collateral Reading

FINAL REPORT OF THE COMMISSION ON MEDICAL EDUCATION

The Commission on Medical Education was organized in 1925 by the Association of American Medical Colleges, "to make a study of the educational principles involved in medical education and licensure, and to make suggestions which would bring them into more satisfactory relationships with the newer conceptions and methods of university education, on the one hand, and with the needs of present-day society, on the other. It was believed that such a study would assist the efforts to develop a program adapted particularly to the educational, economic and social conditions in this country." The Commission was composed of such nationally known physicians and educators as A. Lawrence Lowell, President of Harvard University (Chairman); and this list of physicians: George Blumer, Walter Bierring, Hugh Cabot, David Edsall, William Darrach, William Allen Pusey, Olin West, Ray Lyman Wilbur, and Willard Rappleye, who was Director of the study. Its report was made public in December 1932, almost coincident with the Report of the Committee on Costs of Medical Care. The 2 reports deal with closely interrelated subjects —indeed they strike at the same general problem from slightly different angles.

The first chapter, on Public Aspects of Medicine, reviews the present economic picture—current trends in medical practice, specialization, laboratory examinations, self-diagnosis, incomes of physicians, distribution of the burden of sickness, sickness insurance, industrial medicine, group practice, etc.

The folowing chapters deal extensively, and with many tables, with these questions: Medical Needs, The Supply and Distribution of Physicians; Post-Graduate Medical Education; The Internship; Medical Licensure; The Medical Course; Opinions Regarding the Medical Training; Premedical Education; The Cost of Medical Education; and Medical Education in Europe.

On the basis of its investigations, the Committee submits a "Summary", which contained many valuable suggestions, but which avoids making specific recommendations—the course which brought the report of the Committee on Costs of Medical Care into such disrepute.

Below we give, first, some significant statements from the body of the report, and then, a condensed version of the "Summary". This material is quoted exactly in the words of the published report:

Owing to the great diversity of local social and economic conditions and the varying degrees of local public opinion regarding sound health policies, no single or artificial program can be imposed upon a given community. The effort must be to educate rather than to legislate.

There is necessity for a clearer conception by the profession as well as by the public of the different needs of individual patients, and a willingness on the part of the latter to pay adequately for a basic non-specialized medical service, which often is far more important and valuable than the services of specialists. A concentration of the medical profession and the public upon a medical service aimed at the early diagnosis, treatment, and prevention of disease would be a fundamental readjustment in the health program which, in the long run, would be beneficial to everyone concerned and would lower the cost of medical care through the prevention of illnesses that are likely to produce disability.

It is highly important that surgeons be trained properly, and that the public as well as the medical profession support efforts to modify the present situation which permits any physician to perform any major operation for which the patient or nearest relative may give consent. There is need of a plan which will guarantee that a physician who undertakes to perform operations is, in fact, competent by training and experience to do so.

The public buys what it is taught to buy, and manufacturers spend between one and two billion dollars a year in that instruction by means of advertising. When the public is convinced of the value of proper medical care, there should be no difficulty in financing an adequate program of medical services, although it may mean curtailing to some extent the expenditures for non-essentials.

If sickness insurance ultimately becomes a reality, perhaps we may have the wisdom to set it up under an organization created for the specific purpose and made up of non-political appointees, somewhat like the boards of regents of the state universities and other governmental bodies of that character.

The medical profession and the public have a joint responsibility in guaranteeing that those who claim to be specialists are in fact experts in their fields. Probably the most satisfactory device would be a public Register of Specialists maintained in each State, admission to which would be granted only on the basis of adequate training and experience.

The most important and largest part of a program of post-graduate education should be directed toward taking educational opportuni-

ties to the practicing physician in his own community or to centers to which he can go without leaving his practice.

It is difficult for the public to understand the importance of legislative protection in regard to medical practice, and it is doubtful whether legislation regarding licensure is of any great benefit to the medical profession in its public responsibilities. The dependence of sound licensing procedures upon public opinion makes it difficult to secure the necessary legislation. The efforts to forward adequate standards and to secure legal definition of those standards have been misunderstood and misinterpreted by the public. They have led to considerable antagonism against the medical profession. The answer to this whole situation lies in the establishment of proper standards of training for the practice of the healing art and the conviction on the part of the public of the importance of a satisfactory training for those who desire to practice. The question is not one of sectarian or scientific belief but of education.

Summary

Education of the public and the organization of modern society are placing new responsibilities upon medicine. Medical knowledge has been put into general circulation. Social changes are having a definite effect upon the physical and mental well-being of the population and upon methods of caring for the health of the people. The physician today needs to be an adviser in regard to health as well as a healer of disease. A wider appreciation of the essential character of medical service will make it a more potent influence in the general welfare of society. The training of physicans should include an emphasis upon the larger social and economic forces as they influence, and are influenced by, medicine. A broader concept of the place which medicine occupies in community life is bound to introduce significant changes in both education and practice.

Changes within the profession are as profound as those in society. Additions to knowledge have been greater in the last 60 years than in the previous 4000. Specialization and division of labor have been inevitable. With them, however, has come a partition of medical services into organs, systems, and technics, with consequent dispersion of responsibility for the patient as a whole, which not infrequently turns out to be unsatisfactory or even harmful.

Specialization and the fragmentation of medical practice have created many services which are not well adjusted to the requirements of individuals and the community, particularly in the larger cities. There is need for the correlation of isolated activities and the coöperative application of knowledge. Not only has the work of the profession been divided into many more or less independent fields, but a variety of other personnel, trained and untrained, have important places in the health program. The public should realize that trained physicians who are familiar with the problems involved and the objectives to be sought should be responsible for the direction of this army of workers.

The greatest health problem of the country is that of making modern medical services available to the entire population. It is apparent that knowledge of the diagnosis, treatment, and prevention of disease is far in advance of its application. The gap between what is known and what is applied has always existed and will continue as additions are made to current knowledge. The extent of that gap, however, can be materially reduced through education of the public, sound regional planning, and the training of physicians and other workers in the broader aspects of the problems involved.

A variety of methods of dealing with different phases of the situation in this country has been developed. The capital requirements of modern practice and the cost of maintaining suitable facilities and personnel, which many practitioners cannot provide, have brought community financial interests into the practice of medicine, thus modifying the relationships and responsibilities of the doctor. These developments are influencing the methods of employing and compensating physicians as well as the conditions under which they work. Several different forms of voluntary sickness insurance are now in use.

Recent publicity regarding the purely economic aspects of the problem has emphasized the present forms and costs rather than the needs and methods of procuring a service of high quality. Everyone familiar with the problems involved is aware of the necessity of securing a more effective and wider application of sound medical services, a better distribution of the economic burden of illness, greater emphasis upon the prevention of disease, and a better and more economical coordination of medical activities. It is essential, however, to keep clearly in mind that the most important factor is the quality of care.

The quality of medical care, in the last analysis, depends upon an intelligent interpretation and correlation of scientific knowledge in its application to the needs of the individual. The educational features are paramount in a sound program of medical services.

There is urgent necessity of articulating more closely the personnel and facilities in order to meet the actual needs of individuals. This cannot be accomplished for everyone by physicians practicing entirely alone. They must coöperate with other physicians, with institutions, laboratories, specialists, community organizations, public-health groups, and other agencies, if the full benefits of modern medical knowledge are to be secured for those who should have different forms of care.

It is urged that standardized medical services should be made available on a mass production basis. The unit of practice, however, whatever the type or degree of organization, is the individual patient.

The burden of illness falls very unevenly on the population and is unpredictable for the individual, which prevents many families from making financial provision for a serious or prolonged sickness. The highly uneven distribution of income in the population complicates the situation further. A large part of the cost of sickness is borne by a small proportion of the people. Some plan of distributing this cost through collective provisions for medical care needs to be worked out. There is considerable propaganda for the adoption of schemes such as those which have been developed in European countries, where the methods of dealing with sickness are inseparably associated with other and larger phases of social legislation. The economic and social factors which led to national sickness insurance abroad are operative in this country, but it is to be hoped that the experiences of other countries will be utilized in the formulation of our schemes, and that they, the latter, will be adapted to the conditions found here.

There is an over-supply of physicians in the country, and there are indications that it will increase. The distribution of doctors is faulty. Through hospital centers, clinics, home nursing, and modern means of transportation can be found a sound solution of this problem. It will not be necessary to resort to artificial programs.

The specialist is an essential element in the modern practice of medicine. Only those who have had a thorough training should be permitted to practice as experts in a limited field, however. A Register of Specialists or some other method should be created in each State, which will provide the public with information regarding those who have a suitable preparation in each field of practice. It is highly important that limited practice be closely related to the actual requirements of patients, and that a wider appreciation be developed in the public of the important place of non-specialized practice in a well-rounded program.

Programs of post-graduate education by joint action of the universities and the profession, designed to provide training in the various specialties and opportunities for those in practice to keep familiar with the latest methods of diagnosis, treatment, and prevention, are essential.

Probably the most important and in some instances the most defective part of medical training is the internship. Effort should be made in every hospital to provide a graduated, practical experience for the intern under close and competent supervision. The requirements of state medical boards and universities in regard to the internship should be flexible, in order to permit students to obtain hospital services which will best fit their preparation, needs, and plans for the future. The aim should be to secure standards, not standardization.

The ultimate functions of the state licensing bodies should be the approval of medical schools, the maintenance of a Register of qualified practitioners, the enforcement of the medical practice acts, certain disciplinary actions against physicians for unprofessional conduct, and participation in the maintenance of a Register of Specialists.

The hope of democracy is in trained leadership. The medical profession is the trustee of the essential knowledge and has the personnel necessary to solve a large national problem. Possessing that knowledge, it is in a position to make a vital contribution to public welfare. Medicine will occupy its proper place in society to the extent that it provides leadership and properly trained personnel for the program of medical service, which should be built upon thoughtfully conceived plans of medical and post-graduate education, proper organization of the profession, and the advocacy of unselfish and courageous public and professional policies.

Sickness affects every member of society sooner or later. Provision must be made to care for it, with full recognition of the technical character of many features of a service designed for that purpose, of the necessity of public education regarding the value and limitations of scientific medicine, and of the importance of creating conditions which will attract and retain the highest type of physician, dentist, nurse, and public-health administrator. There is urgent need for the coördination of the efforts of the various groups and individuals in the field to obviate the inadequacies of isolated and duplicating activities, to secure collective expressions of policy, and

active participation of all in the common undertaking.

Success in the war on disease is not a matter of physical equipment, organizations, numbers of professional workers, or even extensive knowledge of the problems involved. It depends primarily upon trained physicians and other workers and the proper articulation of the necessary facilities and personnel for education and medical care. A sound solution requires the joint efforts of the medical, nursing, and dental professions, hospitals, public-health departments, medical schools, social agencies, universities, and licensing bodies in each State in a regional program designed to meet the needs of the area concerned. Every existing agency should be mobilized, and new provision created where necessary, to insure a competent medical service for the population and a permanent educational plan which will guarantee the continuance of that service. Emphasis must be kept constantly upon the fact that only through a sufficient number of properly trained physicians can a community expect to meet its responsibility for the care and prevention of illness and the protection of health. There is no substitute for this essential feature.

A realization of these responsibilities is introducing new thinking into the profession and challenges the highest order of leadership to make current and future knowledge of the diagnosis, treatment, and prevention of disease available to everyone, a leadership which should be the contribution of the medical profession and of medical education to modern society.

IS POSSIBLE ILLNESS INCLUDED IN YOUR ANNUAL BUDGET?

So many other matters, of such seemingly greater importance, have held our attention recently, that this Journal Department has been seriously neglected. This month, however, at least 1 new book so persistently demands consideration that we cannot ignore its claims. Anticipating that publication of the Report of the Committee on the Costs of Medical Care would bear some literary fruit, it is not surprising that the outstanding book of the moment, and the first of its type to follow up the above-mentioned Report, carries the title—"How to Budget Health"—and, as it is certain to be read by the laity, we urge physicians to read it promptly and thoughtfully. In so far, however, as a review of Mr. Clark's book may be helpful to those physicians who are too busy to read it in its entirety, or who cannot easily secure a copy, we offer this substitute.

How to Budget Health, by Evans Clark, published by Harper & Brothers, 1933, $4.

The author of this book is Director of the Twentieth Century Fund, the President of which is Mr. Edward Filene. This Fund is one of those which participated in underwriting the "Committee on the Costs of Medical Care". At the annual meeting of the Board of Trustees of this Fund, in May 1930, an appropriation was made to finance a study of the practicability of the Medical Guild plan, on the assumption that it gave genuine promise of remedying some existing evils, and this volume is a condensed account of the findings of that investigation, pursued independently of the Committee. The plan discussed has these objectives: (1) to enable the individual of moderate means to budget his doctor's bills annually on a basis of adequate medical care at a relatively reasonable cost; (2) to permit the majority of physicians to secure fair and stabilized incomes; and, (3) at the same time, with reduced costs to the individual, to render service of improved quality compared with what he has been able to buy. It comes as a sort of sequel to the *Report* and offers for public consideration one specific application of the basic principles outlined in more general form among the Committee's *Recommendations*.

The term *Medical Guild* is used to indicate an institution which combines: (1) an all-round medical service, including hospitalization, without any drastic limitations and exceptions, through a selected and adjusted group of physicians; (2) a fixed annual fee covering such service—special as well as general; and (3) periodic health examinations.

The Guild Plan is outlined, and its advantages cited, including the claim that it promises professional independence. "It offers a way whereby control of the profession, by either the State or the Industrial Machine may be avoided, and the advantages of each to the public preserved. * * * Privately operated, voluntary, medical guilds might well furnish the most effective mechanism through which the State, corporations or philanthropy would assist the individual to bear the costs of medical care. Medical guilds could furnish the medical care, and the State, the employer or the philanthropist could help to pay the dues of those who could not afford to meet the entire amount themselves. Medical guilds, if sufficiently widely organized, might in fact be the medium through which some sort of compulsory health insurance might operate—should this be found socially necessary in this country—without interference with private initia-

tive and professional control. * * * The guild plan offers an immediate possibility to large employers of labor to obtain adequate medical service for their employees without instituting and operating medical departments of their own. Corporations, universities and other organizations with large pay-rolls, might find it distinctly to their advantage to contract with medical guilds to take care of the health of their employee staffs."

So much for the preamble. Because, before any plan for social change is promoted, it is well to know what is to be changed, and why, a review is given of American medical service as it exists today; based mainly on the findings of the Committee on Costs of Medical Care. The conclusion is drawn that at least 1/3 of the physicians of this country are under-paid in terms of the cost of maintaining a minimum standard of decent living; some 40,000 physicians having received less than $2500 net in 1929, *the boom year.*

The central problem of medical economics in the United States is considered not so much one of high costs as it is of a more effective distribution of the expense. It is explained that the medical guild plan was shaped to reduce costs and divide their burden in 4 ways: coördination of personnel; reduction of overhead expenses and business risks; elimination of waste and unproductive time and energy of practitioners; and, thorough periodic medical examinations so as to enable physicians to detect defects and illnesses in their early stages, when effective cure should be easier and cheaper.

A summary is then given of experience with the first of the essential elements of the medical guild plan—group practice—in its various forms, to show how this has proved its worth in actual practice. Such groups as the Cornell Clinic, Mental Hygiene Institute in Philadelphia, the plan tried at the Massachusetts General Hospital, and some private group practice units, are considered. Some of these units closely approximate the form of organization suggested for the medical guild, but none of them offers complete service to the general public on an annual fee basis, nor do they combine such service with periodic health examinations. It is a basic principle of the guild plan that the groups which give the medical service must be independent and self-governing—not adjuncts of some other institution primarily engaged in activities other than maintenance of health. From this point of view, the private group practice units are closer to the guild idea than are the industrial or university medical services. Yet, the latter often show an application of all the guild principles.

The second essential element of the guild program—application of group payment principles to medical care—is then considered. A clear distinction is made between the term "group payment", as used to describe the annual fee feature of the medical guild program, and "insurance" as it is commonly understood. After a discussion of group payment and insurance as applied in Foreign Countries and in the United States, it is concluded that insurance is being widely applied to the problem of sickness and disability; that other countries are far in the lead in this development; and that here, the principle of State compulsion has made its most rapid headway in the field of industrial accidents. It is deduced that the time is ripe in this country for some more satisfactory form of group payment for the expenses of illness, and that—*"if this is not offered through the voluntary action of the medical profession and forward-looking laymen, some form of State compulsion is inevitable."*

The value of the third essential of the guild program, periodic examinations, is discussed mainly from the point of view of early detection of illness or defects, and consequent reduction of morbidity and mortality.

The question of what services should be offered, is discussed and the conclusions reached that the more complete the coverage, the more attractive the membership; based on the results of a questionnaire sent to lay people, asking what they would like in the way of service and how much they would be willing to pay if such a guild were organized. The answer to the last question averaged $50 per annum per person.

The problem of *quality* of services offered is discussed, with the conclusion that for an initial guild experiment in a large city, the *quality should be the highest it is possible to obtain.* Such questions as independence versus affiliation, management, and profits, were also discussed, and all with full consideration of medical ethics, and of the fact that no layman is qualified to deal with medical problems by himself.

A possible guild is then outlined, to care for 15,000 subscribers, at an approximate fee of $50 each. It is suggested that it would require an 80-room equipment; a staff of 22 full-time and 7 part-time physicians and surgeons; 10 full-time dentists; a supplementary staff composed of a business manager and assistant; 3 laboratory and x-ray assistants; 14 nurses and assistants; 2 private secretaries; 18 stenographers and file clerks. Subscribers would receive an annual physical examination, and every form of medical, surgical and dental

service—except, that tuberculous and mentally diseased patients would not be enrolled.

In an attempt to secure the opinion of the medical profession regarding such a guild, 17 prominent physicians, including Drs. Samuel Kopetzky, William Ross, Alec Thomson, Eugene Pool and Linsly Williams, were consulted; of whom 12 were genuinely sympathetic, 3 non-committal, and 2 definitely opposed.

The book is, on the whole, clear and unbiased, and the scheme set forth deserves consideration by the profession, if for no other reason than that it seems highly probable that one of the Foundations will attempt to put it to a practical test. It is hardly likely that after such an investigation has been conducted, and with such a result, the entire effort will be discarded by its sponsors. But, whatever the future may hold for us on that score, it is well to prepare oneself for discussion with our patients.

Important Notice

AMENDMENTS TO THE CONSTITUTION

At the Annual Meeting of the Medical Society of New Jersey, in June 1932, Dr. Frederic J. Quigley, as Chairman of the Reference Committee on the Constitution and By-Laws, submitted several proposed amendments to the Constitution which had been approved by that Committee, and at the conclusion of their reading (Sept. Sup., pp. 2-3), said: "This constitutes a *first reading,* and * * * having now been read, they will lay over until next year for action."

Article XII—says: "This Constitution may be amended by a two-thirds vote of the members present at any Annual Meeting, provided the proposed amendments have been considered by the Committee on Revision of the Constitution and By-Laws, and that they shall have been submitted in writing at a previous Annual Meeting, shall have been published in the Journal of this Society, and officially sent to each component society at least three (3) months before the Annual Meeting at which final action is to be taken."

The amendments to be voted on at the approaching Annual Meeting, we understand, are:

Article IV—Sec. 1.—(p. 6 of the copy printed in 1929). Strike out entire wording and substitute: "This Society shall be composed of Fellows, Officers, Delegates and members of Component Societies in good standing."

Art. IV.—Sec. 3 (c)—(p. 7). Strike out subsection.

Art. IV.—Sec. 3 (d)—(p. 8). Strike out "a"—in the second line.

Art. IV. Sec. 3. (d) and (e)—(p. 8). Change to subsections (c) and (d) respectively.

Art. IV. Sec. 3 (f)—(p. 8). Strike out the word "his" (last line on p. 8—last word) and substitute the word "an".

Art. IV. Sec. 4 (p. 9). Strike out entire wording and substitute: "All members of Component Societies in good standing are hereby constituted members of this Society, and entitled to participate in all the privileges of general and scientific sessions."

Art. VI. (p. 10) (first line). Strike out the comma "," and the word "three (3)"—and substitute: "President-Elect and two (2)".

Art. VIII., Sec. 2. (p. 10). After the word "Delegates" (first line of section) and before the word "may", insert the words "or the Board of Trustees".

Art. IX. Sec. 2. (p. 11). Strike out the numeral "3" (fifth line of section) and substitute: "President-Elect and two (2)".

Current Events

TRI-STATE MEDICAL CONFERENCE

February 18, 1933

The Tri-State Medical Conference convened at Hotel Pennsylvania, New York City, February 18, 1933, at 10.30 a. m., with Dr. Charles Gordon Heyd, President of the New York State Medical Society, in the Chair, and the following Members and Guests in attendance:

New York: Charles Gordon Heyd, New York City; Frank Overton, New York City; Joseph S. Lawrence, Albany; N. B. Van Etten, New York City; J. E. Sadlier, Poughkeepsie; and Stuart B. Blakeley, Binghamton, Councilor Sixth District.

Pennsylvania: Donald Guthrie, Sayre; W. F. Donaldson, Pittsburgh; F. C. Hammond, Philadelphia; and Edgar S. Buyers, Norristown.

New Jersey: Frederic J. Quigley, Union City; J. F. Hagerty, Newark; J. B. Morrison, Newark; and H. O. Reik, Atlantic City.

Guests: W. C. Rappleye, New York City; H. W. Davis, Binghamton; Alec N. Thomson, Brooklyn; E. S. Sherman, Newark; and B. S. Pollak, Secaucus, N. J.

Expressions of regret at their inability to attend the Conference were received from Drs.: D. S. Dougherty, New York City; G. N. J. Sommer, Trenton, N. J.; William T. Sharpless, West Chester, Pa.; L. F. Donohoe, Bayonne, N. J.; James N. Vander Veer, Albany, N. Y.; and William H. Ross, Roslyn, L. I.

Dr. Charles Gordon Heyd, New York City (presiding), called upon Dr. Davis for the first paper on the program.

DESCRIPTION OF THE ENDICOTT-JOHNSON CLINIC

Howard W. Davis, M.D.,
Binghamton, N. Y.

As you no doubt know, the Endicott-Johnson Corporation is one of the largest manufacturers of shoes and tanners of leather. In 1915-16 they started with 1 physician and 1 nurse to look after accidents and illness as emergencies among their employees. In the latter part of 1916-17 the Johnsons, who were at that time in control of the corporation, put some of the local physicians to work on a regular fee basis. In the latter part of 1917 they hired the first full-time physician to take care of the families connected with the industry and from then on their Medical Department has grown rapidly.

Their idea is that anybody who works for the Company is entitled to absolutely full medical care, hospitalization, surgery or any sort of medical care that may be needed; and that any member of the workman's dependent family is also entitled to care. In 1919, when I first went with the Company, they were employing about 20 physicians. At that time they had 1 surgeon and 1 nurse for surgical emergencies, and any special work was paid for by the Company but to local specialists. In 1922 they sent a man who had been with them for a short time to the University of Pennsylvania for a short course in nose and throat work, and for about 7 years thereafter 1 man was sent away each year for a full year of post-graduate study, the Corporation paying his tuition and incidental expenses such as books and laboratory supplies, and also his full salary. In 1925-26 they had 1 full-time surgeon, 2 full-time nose and throat specialists, 1 ophthalmologist, 1 internist, 1 obstetrician, 3-4 licensed pharmacists, 1 physiotherapist, and 2 laboratory technicians or bacteriologists.

They have a medical building in one section of Binghamton which is inhabited largely by Slavic people, also a building in Johnson City, and also a separate plant in Endicott which is 5 miles away. Each department has its own medical staff. Workers may come in and ask for any doctor they choose, during the hours from 8 to 6. At night they have to take the doctor who is on call. There are also 2 hospitals where their patients are sent. One of those was formerly the Johnson City Hospital, which was owned by a private surgeon in Johnson City. At his death, in 1926, the Endicott-Johnson Corporation purchased the hospital from his estate, at a cost of $100,000 and at about the same time Mr. George F. Johnson donated an amount of money to the City of Endicott to build the "Ideal Hospital". The doctors who are doing general work visit the patient in his home and, if he needs hospitalization, the ambulance is sent, the patient admitted to the hospital, and there he stays as long as necessary without any expense whatsoever to himself. Before the depression, if a patient was seriously ill and needed 1 or even 2 special nurses, the Company paid also for the nurses; in other words, they paid for absolutely everything that the patient needed. If consultation became necessary and was not available within the organization, the Company also paid for securing that.

At about this same time the Company bought a farm 6-7 miles from the city for "convalescent girls and women". Tuberculous patients constantly being discovered, the Company decided to rent 1 or more cottages at Saranac Lake and to send these patients there for cure, and they also employed a doctor to take care of the other tuberculous patients at home.

Prior to 1929, each of these units, at Binghamton, Endicott and Johnson City, had its own "maternity ward" in the building, but since then in order to economize on the cost of nursing care, it was decided to send all maternity patients to other hospitals and close up their maternity wards. The same may be said now for the nose and throat patients.

To give you some idea of how much they have spent in the past 5 years; in 1927, their total cost for the Medical Department was $789,074.81. The average number of workers on the pay roll was 15,539; the number of physicians on the staff 24; and the total number of nurses 65. In 1928, they spent $826,424.43. The average number of workers was 14,478; the number of physicians 24; the number of nurses 67. In 1929, the amount of money spent was $759,944.12; the number of workers 14,698; an increase of 1 physician, making the number 25; and the nurses dropped from 67 to 36, due to transferring the maternity patients. In 1930, the total expense was $796,650.03; number of workers 14,843; number of physicians 30; and number of nurses 36. In 1931, the expenditure was $673,389.51; number of workers 15,317; 31 physicians; and 22 nurses. In 1932, total expenditure $705,535.67; number of workers 15,580; number of physicians 35; number of nurses 22. Now, in the years of 1927, '28, '29, '30 the charge for the ambulance is not included because that was charged up to "efficiency". The cost of taking care of compensation work is not included in these figures because that is charged against "profits" of the Company and the Medical Department is given credit for the salary of 1 full-time physician, 2 clerks, 2 nurses and 1 physiotherapist at the rate of $2 per treatment. Taxes are also not included in these figures, but are prorated and charged to capital expense. The capital involved in the purchase of these buildings is not included. Heat and light are charged against these figures.

To give you some idea of the amount of work done by the physicians: in 1932, there were 34 full-time and 2 part-time physicians, and office calls numbered 145,414: home and hospital calls, 103,693. Obstetric cases, 696. First-aid dressings for "compensation" patients, 3107; subsequent dressings 31,055. Massage and electric treatments, 18,198. Alpine light treatments, 15,308. Kromeyer light treatments, 3245. Fractures, 200. Intravenous and vaccine injections, 4441. Pneumothorax, 264. Bile drainage and gastrics, 605. Laboratory tests, 31,938. Special treatments, such as luetic, 9182. Cystoscopics (Neo-ipex and Skiodans) 241. Sigmoidoscopic, 55. Consultations, 1131. Radiographs taken, 2993. Major operations, 631. Minor operations, 737. Assisting at operations, 427. Ear, nose and throat operations, 1380. Ear, nose and throat treatments, 19,059. Bronchoscopic examinations, 73. Eye operations, 120. Eye treatments, 3150.

Refractions, 2188. Dental cleanings, 4670. Dental fillings, 11,203. Dental extractions, 15,170. Dental treatments, 9820. Special dental work, 563. Anesthesias, 877. Visiting-nurse calls, 10,807. Basal metabolisms, 77.

I might mention that they have 3 dentists, but do no gold work or bridge work. They are now doing some orthodontic work.

At the same time they started the medical department they also started a free legal service, and I think they have about 8-10 lawyers who will take care of any legal work except domestic difficulties and divorces. The Company also takes care of the deficit at the Ideal Hospital, which is supposed to be a community affair, and in 1930 that deficit was $13,968. In 1929 the deficit was $11,234. The deficit at the Endicott Memorial Hospital in 1929 was $10,900. In 1930 they put in a steam line to supply heat to the Memorial Hospital at a cost of about $29,000.

Dr. Morrison: How much of that total expenditure for medical costs went to the physicians?

Dr. Davis: About $175,000.

Dr. Morrison: That is, in payment of 145,000 office calls, 103,000 home visits, and 600 obstetric cases?

Dr. Davis: Yes! I might say that the average type of physician who started there 10-12 years ago was either the *young* doctor, just out of his hospital internship, or just coming out of the Army, or else the doctor who had been in practice in some other community and for some reason desired to make a change and have a full-time job. As time passed they tried to select their own physicians, and the average doctor whom they now get is a young man, and in charge of all this medical work there is a layman who is called the Medical Director.

Dr. Heyd: How long a time do the doctors usually stay with the Company? Have some been with them since the inception of the scheme?

Dr. Davis: Yes, 1 doctor who started with them originally, doing the compensation work, is still with them.

Dr. Heyd: What salary does he draw?

Dr. Davis: I do not know. In the beginning the service was paid for entirely by the Company and there was a policy of salary and a dividing of the profits between the stock-holders and the workers, and later a bonus system was developed; that is the workers would get a bonus if the Company made any money, but the largest bonus paid was about $250. About 2 years ago they decided to deduct 5% of the workers' pay to carry the cost of medical care, and that is being done today. Prior to that it did not cost the workers anything. If they wanted to avail themselves of the Endicott-Johnson medical service they could do so, but if they wanted to employ and pay their own physician that was their privilege. However, they have tried to influence the people to use the Company's Medical Department. If the employee desires to have his own physician, the corporation does not pay his hospital, x-ray or any other laboratory expenses. I understand that the 5% salary deduction more than pays the cost of medical service.

Dr. Heyd: These men would make an average of $1800 a year, or $30 a week, would they not?

Dr. Davis: I do not think the average is as high as that. The last time I heard anything about it the average worker's pay was around $24 a week.

Dr. Morrison: The maternity cases, are they deducted from that gross total?

Dr. Davis: Yes, but there are many major operations in that list also.

Dr. Morrison: I suppose the 103,000 home and hospital calls include all of the office work, nose and throat treatments, cystoscopic work, etc.?

Dr. Davis: No, it does not, but look at the number of major services.

Dr. Heyd: How long do the doctors stay? What is their turn-over in the personnel, roughly speaking?

Dr. Davis: Some of them have stayed but a short time and others quite a long time. I was with them about nine and a quarter years.

Dr. Heyd: Is their professional turn-over comparable to the industrial turn-over as a whole?

Dr. Davis: No, I do not think so. Of course, with 35 physicians they have had quite a turn-over but not perhaps greater than in any other group of physicians over a period of 13 or 14 years.

Dr. Donaldson: Do they make any deduction from their salaries for legal service?

Dr. Davis: No. The 5% probably helps take care of the legal service. In the past 14 years they have sent 7 physicians off for post-graduate courses of 1 year each, and 12 or 13 other physicians have had a shorter study course—4-6 weeks in orthopedics or some other special branch. They have sent 3 away for courses in cystoscopy; 1 to Long Island for 3 months of maternity work; and 3 were sent to Dr. Trudeau, in Saranac, to take a course in tuberculosis work.

Dr. Heyd: Dr. Blakeley is also familiar with this work. Perhaps he would like to discuss the subject.

Dr. Blakeley: I think Dr. Davis has covered the subject very well. I believe every one must admit that the Company has given excellent service to its employees. How each person feels in regard to the cost of his medical care is a difficult question to answer. It is generally felt that more money is spent than is necessary; that some patients are hospitalized, who need not have been so treated; and, it is also believed that some of the figures are padded, the number of house and office calls are considerably padded.

Dr. Davis: I know that to be true, because when I first became connected with the corporation some of the physicians used to report their house and office calls as 50, 60 or 70 calls a day; it being thought that the Company would rate the doctor's efficiency and ability on his number of house calls per day. I padded my own figures at first but did not have to do that after 1924.

Dr. Morrison: Are these resident physicians, with their living expenses paid?

Dr. Davis: Oh, no. The doctors receive about $3250, and have to furnish their own automobile and pay its running expenses. Before the depression they were started in at $3000 salary and $900 allowance for a car.

Dr. Buyers: Does that 5% cover the medical costs to the worker and also his dependents?

Dr. Davis: Yes, it includes all of his dependents, and I think they have never made a survey to find out how many dependents there are per worker.

Dr. Buyers: Does the worker who has no dependents pay the same as the one who has 5 or 6?

Dr. Davis: Yes.

Dr. Quigley: What is the feeling of the workers regarding the service?

Dr. Davis: Some of them prefer to pay their own physicians; others are happy with the service.

Dr. Sadlier: Have you any figures as to the number of workers who use the company physicians?

Dr. Davis: No, I have not, but I think the figure has risen in the past few years. The percentage of workers being taken care of by private physicians is much less than it was 10 years ago, but I have no exact figures on that point.

Dr. Quigley: Is there any other major industry in the town?

Dr. Davis: Yes, there are several others in Binghamton.

Dr. Blakeley: In the report of the Committee I think a great deal has been said about the number of employees who use the medical service of the corporation.

Dr. Morrison: The number must be high when there are 140,000 office calls for 14,000 employees.

Dr. Davis: Of course, that includes all members of their families.

Dr. Blakeley: I think the attitude of the administration has changed. Now, they rather encourage the workers to take advantage of this service.

Dr. Heyd: How do these physicians fit in with the local medical society? Are they members of that society?

Dr. Davis: I was the first doctor who tried to get into the County Society, in 1920, and had rather a hard time to do it.

Dr. Heyd: Are the doctors contract physicians? Do they share in the bonuses?

Dr. Davis: Yes. Roughly, the average salary is $9000 a year. At the time when I left, I was getting $9200 a year plus the bonus, also another special bonus which was 0.1% of the net profit. Only 4 of us were getting that bonus. The last year I was with the Company, which was one of the best years they ever had, the bonus was around $3200; so, the Company actually paid me about $12,400.

Dr. Heyd: Did you have any professional upkeep?

Dr. Davis: Nothing except my automobile.

Dr. Lawrence: Do these physicians engage in outside practice?

Dr. Davis: Yes, but the corporation does not favor that practice.

I might say also, that they have a *relief system*, the worker paying 25 cents a week is entitled to $10 a week when out because of sickness. There is also an *old-age pension*, though, in so far as I know, no physician has ever been pensioned. In fact, I remember, one physician, in particular, who had been with the Company 14 years, was discharged a year or so ago, and was not pensioned. The Company physicians do little in the way of preventive medicine. They do have pre-natal clinics, and the Company coöperates with and, I think, pays the salary of one of the school nurses. Some work in the toxin-antitoxin campaign was done in the schools but no other preventive medicine work is undertaken.

Dr. Morrison: Do the employees have periodic examinations?

Dr. Davis: No, but when a man first goes to work with the corporation he has to be examined, a Wassermann test is taken, etc. If a worker has a wife and several children and develops tuberculosis, he is sent to Saranac and receives excellent care there. He may stay a year or 3 years and have all of his expenses paid. He is also given $1 or $2 a week for cigarette or stamp money and his family is taken care of. If he comes back from Saranac, there is no provision made for a part-time job. He works full hours and if he breaks down within 6 months or a year, will be sent back to Saranac. No attempt is made to find out if any other member of this man's family is tuberculous, or not unless the individual physician takes on this responsibility.

Dr. Quigley: Have the doctors had anything to say at all in determining these policies?

Dr. Davis: Very little. The lay organization takes care of that.

Dr. Heyd: Do they have much labor trouble?

Dr. Davis: No, very little.

Dr. Heyd: What nursing service is provided?

Dr. Davis: They have visiting nurses.

Dr. Heyd: Do they supply a nurse at the home, for a patient with pneumonia, for instance?

Dr. Davis: Oh, yes. In 1927, they paid outside nurses $40,580; in 1928, $39,306; in 1929, $25,476; in 1930, $10,087; 1931, $7978; and in 1932, $9078. When business was good, the patient could have had 2 nurses if desired, and I have had as many as 4 nurses for 1 patient. The corporation paid for everything. In 1927, outside physicians received $34,263; in 1928, $38,878; in 1929, $23,678; in 1930, $16,077; in 1931, $26,168; and in 1932, $13,168.

Dr. Heyd: What is your feeling as to the sum total of medical service? Is it superior or comparable to what the whole group of 14,000 would get, in an ordinary community?

Dr. Davis: I think the service from some of the physicians there compares favorably to the best service that they could purchase in any community. On the other hand, my feeling is that the average doctor doing house work might not be as good as the average physician who is being paid personally by the patient. I feel that the specialists are doing good work but that the men in general practice do not take the same interest.

Dr. Buyers: Are these hospitals inspected by the American College of Surgeons?

Dr. Davis: Yes. One of the hospitals has 94 beds and 2 bassinets; Johnson City Hospital has 174 beds and 26 bassinets. I am sure that both hospitals are recognized by the College. The hospital in Johnson City has a training school; the one in Endicott does not.

Question: Do some of these physicians, by virtue of doing outside work, gradually get away from the Company and start practice in the town?

Dr. Davis: Yes, a lot of them do. There are 10-12 physicians located in Binghamton right now who started with the Company.

Dr. Heyd: Why do they leave?

Dr. Davis: Some of them just became dissatisfied, and want a change.

Dr. Donaldson: You spoke of another shoe company in Binghamton. Has it a similar service?

Dr. Davis: Yes, but it allows free choice of physicians and the medical service is not as extensive as the Endicott-Johnson.

Dr. Donaldson: Does that plant pay any more in cash to its employees?

Dr. Davis: That, I do not know, and, I do not know what the average income is at Endicott-Johnson.

Dr. Morrison: Is that free choice of physicians confined to a number of stipulated physicians, or may they have free choice of anybody in town?

Dr. Blakeley: Theoretically, it is a free choice of any one in town, but whether that is true in practice, I do not know.

Dr. Lawrence: Some 2-3 years ago, I was once traveling east from Elmira when there was a group of young people on the train who, I gathered, were Endicott-Johnson employees who had been down south, in South Carolina, making a study of what mills down there were doing, and they were talking about medical service. Is there in the plant a group interested in organizing or developing such medical service?

Dr. Davis: Not to my knowledge.

Dr. Lawrence: I was wondering whether they were sent down there, and inferred that they were. They seemed to be preparing reports on the plants they had visited, as compared with their own.

Dr. Sadlier: What proportion of the people of the town are employees of Endicott-Johnson?

Dr. Davis: I think the proportion in Johnson City is greater than in Endicott. However, there are several small industries in Johnson City other than the Endicott-Johnson. I might say that an employee has to work 6 months for the company before he is entitled to the privileges of the medical department. Whether they have changed that scheme since deducting the 5% for medical service, I do not know.

Dr. Heyd: Is there a tendency for the Company to make the cost of medical service large, as an off-set to the idea that these are benefits they are conferring upon the employees?

Dr. Davis: No, I don't believe so. I do feel that some years ago, back in 1923, '24 and '25 the Company spent money freely but not with the idea of trying to evade taxes. The medical service grew so fast that it just could not keep track of the money end of it until the year was over.

Dr. Sadlier: As to the vital statistics in the State of New York, do you know anything about the communities of relatively small size? Do they have a higher or lower rate? In 1932, in New York State, it was 11.2. In Endicott and in Johnson City, Is it about that average?

Dr. Davis: I do not know and I do not believe that any one there has ever been interested in figuring that out.

Dr. Sadlier: There has never been any study made as to the comparative value of services rendered in those 2 communities and other communities of the State?

Dr. Davis: No. The only study made was that made by the National Committee.

Dr. Quigley: Does that refer to normal times or the present year?

Dr. Davis: In 1932, they had 15,580 workers, a slight increase over other years.

Dr. Quigley: That makes a proportion of 1 doctor to about 600 workers?

Dr. Davis: No! You forget that these doctors take care also of the families of the workers, and some of the families have 6 or 7 members, 4 to a family being the average that the Medical Director used to quote, but the Committee on Medical Costs put the figure at 2.3. Sometimes 4 or 5 members of a family work for the Company. Dr. Blakeley brings up the question that the Company does not own all the hospitals it uses but does own the Johnson City Hospital and the Endicott Memorial Hospital.

Dr. Heyd: Those are tax exempt, are they not?

Dr. Davis: Yes. The Ideal Hospital was given to the village of Endicott. The question was asked whether the Company had any one inspecting the families. I forgot to mention that Mr. Platt, who was on the news-paper staff, and who is the lay Director of the Medical Service, did go to Czecho-Slovakia and inspected Banters' factories in 1927 or '28. There has been some speculation that, perhaps, when George F. Johnson dies the idea will also dle.

Letters have been received from Detroit, asking about the Endicott-Johnson servlce and whether the corporation provides medical treatment for members of the family who have been discharged from work because of the depression. Most naturally they do not. As soon as connection with the factory is severed, if such people have no funds to pay for service they have to be taken care of by local charity and local physicians.

Dr. Donaldson: Do the local physicians resent these people coming to them, or are they generous about it?

Dr. Davis: I think the doctors are paid by the County for taking care of such persons.

Dr. Donaldson: What County are you in?

Dr. Davis: Broome County.

Dr. Heyd: If a man has been paying a premium, does he lose that on being discharged? There must be many men who have not availed themselves of this service but who have been paying $50 a year for a number of years.

Dr. Davis: They have only been paying that for a few years.

Dr. Heyd: What percentage of the 15,000 employees and their families avail themselves of the service in any one year?

Dr. Davis: I have no idea and I think the Company has had no way of checking up on that.

Dr. Heyd: Is there any objection on the part of the employees to this deduction for medical servlce?

Dr. Davis: Yes, but what can they do?

Dr. Donaldson: Are the employees nationally organized?

Dr. Davis: No, that is not permitted.

Dr. Heyd: Well, Dr. Davis, we are very grateful to you for this information. It has illuminated many things for me.

We will now go on to a discussion of the next subject, "An Analysis of the Report of the Education Commission", by Dr. Rappleye.

AN ANALYSIS OF THE FINAL REPORT OF THE COMMISSION ON MEDICAL EDUCATION

Willard C. Rappleye, M.D.,

Dean of College of Physicians and Surgeons, Columbia University, and Director of Study of the Commission on Medical Education, New York City

One of the most interesting things about this Commission is its origin and general composition. It originated within the Medical Colleges, the Council of the American Medical Association and the Federation of State Medical Boards. The make-up of the Commission was the first attempt to bring all of these groups together for the purpose of studying our common problems. It has done a monumental piece of work in this country. Representatives of general education, medical scientists, public health officials, clinical teachers and the representatives of licensing boards in the United States, all sat together and tried to work out this general problem.

While the Commission is entirely independent, every effort was made to use agencies already in the field.

The first thing we tried to do was to find out what is the function of the physician and what is the job of medicine in society. We have made many efforts to get at the subject but there are 2 or 3 things that we tried especially to bring out and emphasize throughout the report; namely, the shifting character of medicine in relation to the needs to be met. The conditions of society are in general fluctuation. The character of medical knowledge and the persons able to deliver medical knowledge are varying all the time. The problem of medical organization is shifting rapidly, and has been doing so for the past 50 years. At first, nearly all of the trained personnel in the health field were physicians. Schools of nursing have come, as an illustration, within 50 years. At the present time, on the other hand, only about 10% of the personnel are now physicians; so, the problem of organizing and directing the personnel is extremely important. Direction of the medical program rests with the medical profession and, while we have to some extent relinquished that control, my belief is that we will take it up again as we should.

Another general group of problems that are fluctuating are the medical needs themselves. With the control of many diseases we have very definitely modified the needs of individual sick persons. Urbanization has done much to bring about this condition. The urban age population has shifted greatly, and will shift further, so that in a short time about 26% of the population will be over 50 years of age, whereas during the Civil War only about 9% of the population were of that age. Those are the kind of things that we tried to bring out in this report.

Now we were blessed in having had an opportunity to discuss this wide gap between what is known and what is applied in medical knowledge, without making a lot of recommendations as to how it is to be done, but we have tried to bring out the fact that there is this very wide gap between what is known of disease and the prevention and control of disease, and what is actually applied as represented by the diseases that we still do not control. There are many figures in the report regarding that phase of the subject. Also, we are aware that while there are these many needs to be met, there are still many physicians not effectively employed in solving our problems. In other words, the young doctors are illustrations in the waste of time, the unused time of physicians in many parts of the country. That is a question associated with the great over-supply of doctors, in my opinion.

We discussed medical economics. Our first chapter is devoted largely to the public aspects of medicine. May I say that the order of this report is different from any other report that has been written, and it has drawn comments from many people as to why we have the report in reverse order, because all other reports have begun with general education and have gone into the graduate field, specialism, etc. We tried to make an analysis of medicine in an effort to find out where the profession fitted into the picture. We then took up the medical needs, post-graduate medicine, and licensure. We wanted to find out what were the problems of the doctor, how he got his license, and what were his problems in the field, before we entered into any discussion as to how we would train a student to fit into that picture. That is the reverse order, and I think it is a desirable way to present it.

We had started our studies of the medical economic situation before the Committee on the Costs of Medical Care but when that Committe was organized we discontinued our studies; although most of our basic material is the same. Our interpretation is, however, very different. There are 2 things concerning medical economics about which everybody agrees. First, is the uneven burden of sickness which the economic aspects of medicine bring to the population. Second, that disease is unpredictable for the individual, a thing that is easily recognized by everybody. Out of those 2 factors grew the attempt to formulate a plan of protection for the public, that first found its concrete construction in the social legislation of Denmark. Then came the National Health Insurance Act of Great Britain, in 1911, which was put through by Lloyd George. The name was changed from *sickness insurance*, in 1911, to *health insurance*. I think that change has had a rather important psychologic effect. Next, it was taken up in France, so that now nearly all of the leading countries of the world have adopted some such insurance against sickness. The most important thing about health insurance (and I think that we have a problem there for medical education as well as for medical service) as seen and studied abroad, is that it is only a part of the much larger problem of "social legislation". That is the thing that the Committee on the Costs of Medical Care seems to have ignored; that is, that sickness insurance never in any country, came first. It has always followed other forms of social disablement insurance, and there is a wide range of possibilities of other hazards to which the employed person is subjected. The idea was, generally, to provide cash for wages lost; in other words, compensation for wages lost. Then came benefits in kind, hospital care, nursing, etc., and they became interested in health restoration as well as cash benefits.

One other thing in regard to the doctors, and that is the method by which physicians are paid, because upon that hinges the whole problem of contracts, however set up, whether by governments, societies, funds or other devices. The Germans, the Swiss, and others relied in the beginning upon the per visit basis of payment. The second group, developing another plan, went on a salary basis, and that was best exemplified in Sweden where about ⅓ of the profession secure positions under the government. That has been proposed in this country, as you know, in some of the western states.

There was a third general plan which constituted a compromise to the so-called competition basis, to cost so much each year, which is best illustrated by the Great Britain plan. Several European countries use the competition basis, but Denmark has used it perhaps most effectively.

In devising any scheme to organize medicine, the first thing to be considered is the quality of the medical men. To devise and guarantee the quality of medical care seems to me the most important thing to be decided in determining upon any plan. The second thing which must be preserved, because it is the biologic and fundamental concept of medicine, is that illness is an individual thing, and the quality of personal care of the patient must be preserved in some form.

We have reviewed, in this report, many of the activities now developing in this country. We referred to the Endicott-Johnson and other plans. There are many devices being put in operation, some of them excellent, in which there has been a *mass purchase of medical services under the guise of insurance.* Group practice, as we see it in the middle-west and southwest—insurance medicine—is growing rapidly and is largely developing out of other forms of insurance, such as life insurance and group industrial insurance, particularly. There is now a great deal of *contract practice* and *group practice* in the south and west, as a development of public health service.

There is one very important thing that we have contributed and which has now become a very much discussed subject. The American Medical Association and other organizations have taken it up and are *considering it a crucial thing;* namely, the supply and distribution of physicians. It is now evident that we have more physicians, relatively, than any other nation in the world; in fact, we have more than twice as many. England and France are illustrations of our over-crowding in the profession of medicine. If we had the same number of doctors in this country that Great Britain has, in comparison with population, we would have about 82,000 physicians. There is the situation. If we had the same number of doctors that Germany has, in comparison with her population, we would have 79,000; but, we have, actually 156,000. In France, they have now 1 to 690 people. Sweden has 1 to 2890. What does all that mean? It means that we are producing more physicians than are needed. We are producing from Class A

medical schools the same number of physicians that we produced when we had 160 medical schools. Reduction in the number of medical schools seems to be increasing the number of doctors graduating. That is an amazing story. We are not only producing more physicians than are needed, but we have many additional doctors coming in here from Europe and Canada. We are producing more physicians than we can possibly absorb and still retain the existing high quality of medical service.

The quality of student going into medicine is another very important item because, the moment a profession becomes over-crowded it is evidence of intelligence that the best men do not go into that profession or, where the conditions are so prescribed, as at present in Germany, that only 5% of the doctors make a living in private practice, the quality of student will come down rapidly.

We had a meeting in Chicago recently of the Council of the American Medical Association, the Federation of State Medical Boards and the Association of Medical Colleges, where it was decided to make representation to all the Medical Examining Boards, and they have adopted a rule—including New York now—that the State Boards will no longer recognize for licensure in their states a student coming from a foreign medical school, who does not possess a license to practice medicine in the country where he studied. That is the most effective and inoffensive way to combat this condition. He can get a license in Great Britain and we have made arrangements with the British Medical Council and the Universities that they will not accept any medical student who is not known to be qualified. Of course, the students now over there would be eligible to return because you cannot make legislation retro-active.

There is now an active movement on in several states—I think New Jersey has taken the leadership—to set up a register of "specialists", with provision for recognizing those who have had adequate preparation and training in one of the specialties. At Chicago we pushed this thing forward and the Council of the American Medical Association, in conjunction with the other bodies, has begun work on *a national register of specialists.* I regret that, although I have tried for 2 years to get New York to take the leadership in this movement, they have not done so. Frankly, I envy you gentlemen of New Jersey, that you took leadership in that matter. I think our Board of Regents should have done it. We tried very hard in Albany to get them to do it, but you got ahead of us. My opinion is that each State will ultimately set up a register of specialists based on records and other information gotten, perhaps, through some arrangement with national organizations, such as the American Medical Association, National Medical Examining Boards, and Universities. I think it is a very important matter, to the profession, and will be of great value to the public.

I have talked a good deal about post-graduate medicine. Some of the universities are taking steps to integrate the problem of medicine, the development of specialists, and providing advanced courses for general practitioners in the field and also for carrying extension courses in medicine.

The problem of medical licensure is very important, in regard to the growing practice of so-called *endorsement,* and the facility with which one can move from one state to another without taking examinations for licensure. A great many—I think 42—States now recognize the National Board of Medical Examiners, but only about 10% of those graduating take the National Board's examination, so that is not solving the problem.

The problem of medical education, as such, I will not discuss except to indicate that we believe, and the Commission believed, that medical schools are really very much interested in all of these problems because we are preparing men to go out and approach a lot of these problems in a rather intelligent way. There has been a tendency in the past to isolate medical education, particularly within the past few years. In the earlier days, when a great deal of the teaching of medicine was done by practical work, there was not the same danger of having medical education isolated. We have drawn our medical teachers back farther and farther into the laboratory and set up a monastery type of medicine. That should be changed and we shall try to do what we can to reverse that trend.

The idea of what a medical course ought to do I will not go into particularly unless there is some reason for discussing the more technical phases of medical training, but one thing is clear, that teaching by medical courses cannot prepare a student for the practice of medicine; they only prepare him to begin the practice of his profession. A new slant on medical education has been developing in all of the students certain methods and habits of study of scientific medicine in order that they may have an armamentarium and intellectual equipment that will stay with them all the rest of their lives. In other words, he is being prepared to be a student for the rest of his professional life.

The unit of courses is a matter of internal organization but we have found that every student has a very definite impression that he successfully studied anatomy and physiology and pathology, each of these courses more or less separated. Now, of course, the trend is toward correlating all of these courses and interdigitating the divisions of a medical faculty. I think it is also more clear now that the aim is to produce a sound, safe and competent practitioner of medicine. The attempt for any one to turn out research men in medicine, or teachers of medicine, has been abandoned. There is no way to select men in advance for any particular work. Several schools have tried it and found that it does not work.

The question of the curriculum I will not speak about except to emphasize the importance of putting the responsibility upon the student for doing a good deal of his own learning. I think that is one of the most important things to emphasize, that medicine is not taught by a faculty but is learned by one's own efforts, and the teaching is a question of stimulating each student instead of spoon-feeding him. You all know how that is done, the elective periods, etc.

This year there are about 14,000 students applying for admission to the medical schools whose capacity is about 6200. Of those who cannot get into the medical schools in this country, many will over-flow abroad. Some of them are reasonably well prepared, but we are not getting anything like the large number of highly desirable students applying for medical courses that we should have. We are getting numbers but not quality. The number of students in the secondary schools of the United States increased 10 times as rapidly as the population. The number of students in our colleges increased 7 times and college graduates increased 8 times as fast as the population.

This is the general ground that our report covered, and I think the most important single thing in our Report on Medical Education is the fact that we made no *recommendations;* we drew some *conclusions,* but made *no recommendations.*

Dr. Heyd: This subject is now open for discussion.

Dr. Morrison: Regarding the number of physi-

cians in relation to the population, the Province of Alberta, in Canada, has stipulated, by law, the number of physicians in relation to the population in the future and no new physician will be registered until the number of physicians falls to that level.

Dr. Rappleye: They will regret that legislation. That has nothing to do with the quality of the physician.

Dr. Quigley: May I ask whether the Commission has given any thought to means that might be employed for further extension of accident and sickness insurance? It seems to me, that is the only type of insurance that would take care of the medical costs and at the same time not interfere with the quality of service, because it leaves it entirely free for the individual to take care of the medical costs from the insurance money that he receives.

Dr. Rappleye: We did not make any special study of that problem, but I live in Connecticut, and up there, every insurance company that has attempted to write sickness and health insurance policies has been obliged to increase its premiums several times because of the unpredictable demands that may be made. You have to be able to predict with reasonable mathematical accuracy what the costs will be. That is why most of these insurance companies have gotten into difficulty. It is impossible to control the fees of the physician and demands upon the carriers for various services, and every company has found that, no matter how carefully it is worked out in advance, that they have later to double the expected financial load. We have no available data in this country, except among certain industrial groups. The Southern Pacific Railroad Company and a few industrial organizations can show by fairly accurate figures what it is likely to cost, but that has been the difficulty in the *voluntary scheme* of insurance, and it is out of such experiences that the *compulsory form* of sickness insurance developed. In Great Britain numerous "Friendly Societies" made contracts with physicians, on one hand, and with individuals, on the other, and thus made mass purchase of sickness insurance possible, just as is proposed now by the United Hospital Fund here in New York. I understand that plan has been approved by the Hospital Association and they are apparently going ahead with its establishment. Every country that has tried *voluntary insurance*, except Denmark and a few of the smaller countries, has found itself unable to keep it on a purely voluntary basis; and it becomes *compulsory* because competing plans offer special inducements to the doctor. Sickness insurance abroad varies considerably in different countries; in some places it is excellent, and you see the best doctors interested in it, but in others it is not so well done, and for a variety of reasons.

Dr. Heyd: Do you think mere bulk is a factor?

Dr. Rappleye: I think control of the thing, the amount of money that becomes involved, and the temperament of the people, all are factors. In Denmark, the physicians are paid much more than in other countries for the same services, and they continue to get a large number of fine students in medicine. There, the doctor is highly regarded by the people, and both, the doctors and the people, are fairly well satisfied; and, the service continues to attract a large number of physicians of fine type.

Dr. Heyd: It is your feeling that any scheme worked out would be in conflict with the profession generally?

Dr. Rappleye: Well, we have no basic legislation of a social character, no public opinion or other safe-guard for setting up a scheme of sickness insurance. One can imagine what might happen if we tried to set it up under some of our State or city governments—for instance, the City of New York, or Chicago, or Philadelphia. You can imagine the political possibilities that would evolve. I think the Committee made a serious mistake, and my own opinion is that the Report has set the thing back 20 years. It was coming rapidly, and the only thing required, to have everybody recognize that situation was to coördinate what was being done. But, to have made a *recommendation which is impracticable*, if not impossible, in this country at the present time, just because it is alleged to have worked satisfactorily in certain other countries, was unwise.

Dr. Heyd: Has there not been a complete breakdown in New Zealand and in some other places where the country was unable to carry the financial burden?

Dr. Rappleye: Yes! That is true, and it is difficult to figure accurately in advance what the cost of it will be, even on the basis of experience. Besides the number of demands that you had not been able to predict, you will find unscrupulous physicians taking advantage of the situation, and making from 6 to 8 visits when 1 should have been sufficient.

Dr. Quigley: The British Medical Association has asked that this scheme be extended to include everybody and all kinds of service, and the implication is that this was done because of satisfaction with the system. Is it not true that physicians not on the Panel were discriminated against so that they were obliged to join it in self-defense?

Dr. Rappleye: No, I talked with men about this, and got an entirely different understanding. The British Medical Association is reasonably well satisfied, in the sense that 90% of those on the Panel are now in favor of it and would not return to the old situation; for one reason, because they are now paid for practice which was formerly on a charity basis.

The British Medical Association has wisely come forward with an extension plan of its own in order to anticipate some unsatisfactory measure in legislation by Parliament. That is where we have made our great mistake in this country, in not coming forward with something that at least looks like a good plan. Of course, the American Medical Association should have been "on its toes" in getting this thing started long ago. The Trustees, it appears, cannot be convinced that they ought to do this. They should have been in a position to say: "We know about this thing, and here are the ways and means for doing it that will insure adequate attention to the patient at fair and reasonable cost."

Dr. Heyd: Is it your feeling that this scheme is a thing apart from, or a part of, the whole socialistic plan?

Dr. Rappleye: It is a part of the whole. I think it should be separated off, and that is why it should be started by the medical group and deal only with the medical profession. The great conflict is over cash benefits and benefits in kind. In other words, there are 2 agencies competing for the same thing. Now, if some medical plan could be set up and the medical service provided on some other basis, but kept under medical control and guidance, and of high professional quality—*that* would be a more desirable thing to do.

Dr. Heyd: Is it your feeling that if the State of New York went further into social organization it would exert influence on the medical schools as to the number of graduates, etc.?

Dr. Rappleye: I don't know whether I can answer that, for the medical schools are, themselves, going to take action to reduce the number of students.

Dr. Hagerty: I wonder if you are familiar with

a movement in Essex County, where there is an attempt to insure workers in industry against hospitalization. It has been tried out, we are told, in Dallas, Texas, for several years and has succeeded fairly well, though they have had to change it somewhat for the type of individuals who hope to benefit under the plan. Many of the physicians in Essex County are opposed to the plan, feeling it will not succeed because of the inclination on the part of the insured to take improper advantage of the insurance benefits. And then, on the other hand, we are fearful that if it does succeed it will be followed further by insurance against doctors' fees.

Dr. Rappleye: That is bound to come.

Dr. Hagerty: The hospital plan is about to be started and it will be interesting to watch how it progresses.

Dr. Morrison: At Elizabeth, they started a campaign through the industries to enroll applicants and have succeeded in getting 1500 during the first month.

Dr. Hagerty: That scheme is worked by a private company. The plan in Essex County has been under organization for 2 months and 1670 workers have applied for the insurance. They will have to secure 10,000 members to make the plan workable and profitable to those who are underwriting the scheme. I feel sure that it will go on the rocks as most of such schemes have.

Dr. Heyd: There is another factor to be considered. In New York City the Post-Graduate and the Beth Israel Hospitals would be in competition in a limited geographic zone of the city. Over in Brooklyn, they propose to put in a 400-bed Municipal Hospital in the Bay Ridge section, though there is not a single individual in that section who does not own his own house.

Dr. Alec Thomson: That is much like the problem of school buildings. There is a need in that section for something more in the way of hospital beds for private service but this being a strictly Municipal Hospital will have an excess of beds.

Dr. Heyd: This question is very apt to affect the quality of medical service throughout the State.

Dr. Rappleye: No doubt it will.

Dr. Quigley: I notice that 2 Philadelphia hospitals have abandoned this hospital insurance plan on the recommendation of the Philadelphia Medical Society.

Dr. Rappleye: When you get hospitals competing, each offering additional inducements, it comes down to dog-eat-dog, and very unsatisfactory because neither can maintain the proper quality of medical care. The significant thing about the Philadelphia scheme is their withdrawal on the ground that they could not act independently.

Dr. Sadlier: Speaking on this subject from the standpoint of the small city and the rural sections as applicable to New York State, I cannot quite see all the difficulties such as I have heard and have read about. I see the young student, coming out today as a graduate in medicine, at least 5 times better prepared than I was. He is a man well prepared having, as Dr. Rappleye says, learned medicine. I see those who are earnest and willing to work succeeding in their profession throughout the State. We see also definite evidence of the medical profession gradually assuming leadership, which it is true they should have assumed to a greater extent years ago. We see the hospitals of the State increasing in size, in quality, and in the type of work they do, and that applies up-state very generally. There are something like 640 hospitals in the State, a large increase in number over a few years ago, most of them ranking as Class A in the American College of Surgeons, and all doing satisfactory and commendable work. We see New York State in 1900 with a mortality rate of 18 per 1000 per year, and we see it in 1932 with a mortality rate of 11.2 per 1000 per year—a gradual but satisfactory saving of life.

Now, with reference to the uneven distribution of the costs of sickness, somehow or other this gets taken care of. I don't know that I could explain just why philanthropic and benevolent-minded people have contributed to hospital construction, overhead, and development, but as a colleague said, at a conference recently held in the western part of New York, when we asked him what happened to the indigent with reference to fees paid to the physician, he looked upon it as the medical profession's contribution to society. I am not speaking from the standpoint of the medical profession in the large city, but from that standpoint in the smaller city in the rural section, about which I know most and with which I have had the opportunity to become acquainted through my association with the Committee of Public Relations of the State Society. We are having conferences all over the State this year, with the Chairmen of our County Committees, and we are finding the medical men taking up their burden and carrying it through properly. I cannot, myself, quite visualize all of the troubles that we seem constantly to be hearing about.

A DIGEST OF THE FINAL REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

N. B. Van Etten, M.D.,
New York City

This paper was read and discussed but withheld from publication for further use.

Dr. Donaldson extended an invitation to the Tri-State Medical Conference to hold its next meeting in Pennsylvania, probably in Philadelphia, and announced that he would appreciate an expression of opinion from any one who desired any particular subjects discussed.

Dr. Reik moved acceptance of Dr. Donaldson's invitation, and the motion was seconded and adopted.

The meeting adjourned at 1 p. m. and luncheon was served in an adjoining room.

WELFARE COMMITTEE MEETING

March 12, 1933

In response to a call regularly issued under direction of its Chairman, Dr. Charles H. Schlichter, the Welfare Committee of the Medical Society of New Jersey met in Trenton, at 2 p. m., on Sunday, March 12, 1933, in the Princeton Room of Hotel Stacy-Trent.

Roll call showed the following members and guests present: Berkow, Bloom, A. H. Coleman, J. G. Coleman, Conaway, Costello, Dandois, Davis, Donohoe, Green, Haggerty, Haussling, Lee, Lippincott, Londrigan, McBride, McMahon, Meigh, Morrison, Mulford, North, Schauffler, Schlichter, Sewall, Sherman, Sommer, Tracy, Ulmer, Quigley, McGuire, Fischelis, of the New Jersey Pharmaceutical Association; Miller and Heller, representing the chiropodists. Excuses were received from: Clayton, Hagerty, Larkey, and Mahaffey.

The Executive Secretary read his report, as follows:

Executive Secretary's Report to the Welfare Committee

The Executive Secretary's report to this meeting will deal almost entirely with matters pertaining

to legislation and to a few of the economic problems at present under consideration by the medical profession throughout the country. Our Chairman, Dr. Schlichter; the Secretary of the State Society, Dr. Morrison; and the Executive Secretary, have received during the past month several communications from other States, and we will present those for your consideration immediately, and follow with a report of the present status of legislation pending in the General Assembly at Trenton.

(1) The first communication is a letter from the Medical Society of New Orleans, Louisiana, and presents the reports of 2 committees, and a resolution to be submitted to other organizations along with an invitation to join in a similar course of action. (a) Under the head of "Report of the Medical Forum", we find that a special committee has been studying federal, state, and private hospitals; medical schools; social service; compensation and insurance companies; clinic abuse; boards of health; and a number of other items more or less closely related to the practice of medicine. (b) Under the heading "Report of Hospital Abuse Committee", we find that a special investigation has been made concerning abuse of hospitals by the people, by politicians, and by the profession.

These reports indicate that the Society is sponsoring and directing a study of local conditions, and we are asked: what this State Society is doing; to what extent our component County Societies are making similar investigations; and, whether we will exchange with them, from time to time, such reports of our work as may be of consequence? The resolution, which they specifically request shall be endorsed and acted upon, reads: "Resolved, That members of the medical profession do hereby solicit the active influence of national Congressional Representatives and Senators, of their respective States, in an effort to promote and pass legislation correcting the injustices and the evils above enumerated" (indicating the Veterans' legislation, etc.).

(2) The New Jersey Casualty Underwriters Association asks our coöperation toward improvement of existing conditions "in the compensation and liability fields", as expressed in this resolution:

"Whereas, premiums have been increasing rapidly in recent years on automobile liability and similar types of insurance, due in great measure to the activities of *ambulance chasing* by both *lawyers and doctors;*

Be It Resolved, That the Bar Association of New Jersey and the Medical Society of New Jersey are requested to cause an investigation to be made of these alleged practices."

In that connection, Dr. Morrison has received a letter from Dr. Paul Keller, asking if any committee appointed for such purpose would join in a conference with the Executive Officers of certain Insurance Companies.

(3) From the Academy of Medicine of Cleveland, Ohio, we have a communication announcing that a Committee on Economics is making an elaborate study of our professional economic problems; submitting a copy of the minutes of that committee's last meeting; and asking if any similar committee now existing or to be appointed by our State Society, will agree to exchange records and reports.

(4) From the Michigan State Medical Society, we have a letter similar to that received from Cleveland and making substantially the same request.

(5) *Legislation.* Dr. Schlichter has received from Dr. Eagleton a plan used by the Legislative Committee of the Illinois State Medical Society for keeping members informed as to pending legislation. It consists of a weekly letter, mimeographed and distributed by mail. The same method is employed in New York State. It is rather expensive, and would seem to be unnecessary in this State so long as the members of this Welfare Committee keep their respective County Society members informed of happenings at these sessions, but Dr. Schlichter asks for an expression of opinion and such action as may to you appear proper.

Since our last meeting a number of new Bills have been introduced into the House of Assembly or the Senate, and we shall herewith submit their individual numbers and their apparent objectives:

A. 106 is a Bill designed to have the members of the Board of Embalmers and Funeral Directors appointed in the same manner as now exists in relation to the Board of Medical Examiners. In so far as we can see, it is a matter of no particular importance to this Society.

A. 110 is a Bill to provide for the regulation and licensing of barbers. In its present form that Bill is shorn of those features to which we have heretofore objected: i. e., the joint control of beauty parlors and the privilege of performing so-called minor surgery for the removal of facial blemishes. In other words, its present status is practically a labor union proposition.

A. 144, 145 and 146 are the School Health Bills, introduced by Dr. Newcomb, and recommended at our last meeting.

A. 170 and 171 are Bills introduced by the Society of Chiropodists. A. 170 is another attempt to define the practice of chiropody, which is essential for the control of those who practice chiropody without having previously secured, by examination, a limited license. We have been endeavoring to secure an amendment in the Committee that would be satisfactory to this organization and to the chiropodists, but the results are not yet ready for announcement. A. 171 is an amendment to the present act proposing to raise the standards of education for future chiropodists and is worthy of endorsement.

A. 188 is a proposed amendment to the Hospital Lien Law, consisting of the following statement: "The hospital shall furnish such injured person or his attorney with a true copy of the hospital records pertaining to such injured person." That appears to be for the attorney's benefit rather than the patient's, and we recommend disapproval.

A. 214, introduced by Dr. Mutchler, of Morris County, is a proposal that "whenever any Board of Education of any school district in this State shall deem it to the best interests of the school children of that district, it may make provisions for the examination of children of pre-school age and such other health services as in its judgment may be required. We scarcely need say that this is far too much power to place in the hands of any Board of Education, and its school medical inspectors.

A. 327, introduced by Mr. Muir, for the licensing of naturopaths by the setting-up of a separate Board of Examiners. It is thoroughly bad in every respect and therefore to be condemned.

S. 125 and 126 are Bills about which our Board of Medical Examiners is at present much disturbed. S. 125 calls for the establishment of a Budget Commissioner; probably a good thing in itself. S. 126, introduced by Mr. Reeves, is the one which is designed to do away with "dedicated funds" and has already been disapproved.

S. 226 has been introduced in the favor of osteopathy and, like the naturopathic Bill, should be killed.

Two other Bills, calling for consideration, are S. 229 and A. 289, consisting of the universal narcotic law. Mr. Barrett has been requested to attend this meeting, or to send a representative, for further

consultation regarding that Bill. A. 289 is a Bill dealing with Barbital and hypnotics, and for that I suppose that Dr. Quigley will report as Chairman of the special committee to study that question.

Respectfully submitted,

Henry O. Reik, M.D.,
Secretary, Welfare Committee.

Upon motion of Dr. Londrigan, the report was received and approved.

Taking up its several items seriatim, the Executive Secretary, upon motion of Dr. Morrison, seconded by Dr. Donohoe, was authorized to respond to the communications from New Orleans and Michigan as he deems best.

Dr. Schlichter asked what action should be taken on the suggestion of adopting the weekly letter plan, used by the Illinois and New York Societies, to keep members informed as to the status of pending legislation.

In this connection, Dr. Quigley suggested that not only should the County Societies be kept informed by their representatives here, and through other channels, but, designated members of this Welfare Committee, representing each County Society, should communicate weekly, on a specified day, to the Executive Secretary, a report concerning local views on legislation and other affairs of interest to the State Society.

It was agreed that the suggestion is good but questionable as to whether it would prove practicable. As an example, Dr. Reik stated that the March Journal will make a belated appearance because he had found it impossible to prepare for the March issue, as was required, a complete list of members of the Nominating Committee; though sought by letter and telegrams for 2 months, the last required name was only received on March 11.

Considerable discussion followed, concerning additional labor and cost, how information is or may be obtained, and how it could best be utilized; the Executive Secretary explaining that the present plan of depending upon members of the Welfare Committee to keep their respective County Societies informed, has worked satisfactorily—seemingly as well as any other plan could—in the practical sense; that he had subscribed to the Legislative Index for its weekly report of proceedings, rather than the Legislative News, a daily report, solely on the grounds of economy; but, that he would try any plan the Committee might advise.

Dr. Haggerty said that he had in previous years subscribed to the News because it occasionally supplied an item of information earlier than it would have come through the Index.

Upon motion of Dr. Londrigan, the Executive Secretary was authorized to subscribe to the News, as well as the Index, if necessary.

Taking up the Acts referred to by the Executive Secretary, they were disposed of as follows:

A. 106 and A. 110, being of no apparent concern to the profession, were laid on the table.

A. 146, we were informed by Dr. Tracy, has been amended or replaced by a substitute, in Committee and the changes are not acceptable to its author, Dr. Newcomb. In consequence, the Welfare Committee withdrew its support of the Act. Further, Dr. J. G. Coleman's motion, that we would approve A. 146 only if restored to the form previously endorsed, was adopted.

A. 147 being called for, Dr. McGuire reported negotiations with the Chiropodists, as conducted by himself and the Executive Secretary, and presented the resulting compromise.

The Chairman requested that Drs. Miller and Heller, representing the Chiropodists, be invited to come in and give direct assurance that the Act in its present form (as accepted by Drs. McGuire and Reik) would be satisfactory if approved by the Welfare Committee.

Dr. Reik escorted Drs. Miller and Heller into the room and introduced them; where-upon, Dr. Schlichter explained what action had been taken, and whether it was agreeable to them.

Drs. Miller and *Heller,* each, endorsed Dr. McGuire's report of negotiations and accepted the conditions stated.

The Chairman then presented the question, and the Welfare Committee voted its approval of A. 170 as revised. Drs. Miller and Heller thanked the Welfare Committee and its representatives for such satisfactory coöperation.

A. 171, being intended to raise educational standards for future chiropodists, required no special action.

A. 188 was discussed and formally disapproved.

A. 289, dealing with Barbital, not in satisfactory form, was left to Dr. Quigley with power to act.

Dr. Quigley requested that the Executive Secretary notify Mr. Bischoff of this action.

A. 327—Naturopathy Bill—was unanimously disapproved.

S. 126, we were informed by Drs. North and McGuire, will be killed.

S. 226—Osteopathy—introduced by Powell, we were told by Dr. Mulford, requires further action, because of its sponsor being susceptible to osteopathic-political influences, and Dr. Mulford suggested that each and every member of our Committee should telegraph Powell, of Delanco, and then bring all possible pressure to bear upon him in opposition to that Bill.

S. 221—Expert Testimony—at request of Dr. Londrigan, was approved with the word "medical" inserted to qualify the character of "expert", as intended.

S. 229, designed to effect the establishment of a "universal" State Law for control of narcotics, was reported by Dr. Green as having been considerably modified at the Conference of our subcommittee with the representatives of Mr. Barrett, who was unable to attend. After discussion, in which Mr. Fischelis, representing the pharmacists, took part, it was voted that, despite the changes made, we should oppose all such legislation on the ground of being unnecessary, on one hand, and inimical to the profession, on the other. The national—Harrison—Act would seem to be sufficient, without any additional State legislation.

The letter from Dr. Paul Keller was, upon motion of Dr. Morrison, referred to Dr. Londrigan, with power.

Dr. McBride reported that the State Society's share of the expense incurred in the employment of Mr. McCarter to speak for the several Examining Boards at the recent "public hearing" on S. 126, is $100. The Committee voted to endorse and approve this item of expense and to refer it to the Board of Trustees.

Dr. Quigley brought up the subject of advertising by radio and expressed the opinion that some action be taken with reference to its control.

Dr. Reik stated that the Tri-State Conference had communicated its displeasure to the Radio Commission several years ago, without effect, but the protest might well be repeated—since conditions were rapidly and steadily growing worse.

Dr. Londrigan moved that the State Society ask the A. M. A. to act in this matter, and, being seconded by Dr. Morrison, the motion was adopted.

Adjournment.

Henry O. Reik, M.D.,
Secretary, Welfare Committee

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AIRPLANE MOSQUITO HELD FEVER SOURCE

(New York Times, March 23)

Air travel on an international scale has brought the problem of mosquito "stowaways" in planes spreading yellow and dengue fever in South American countries to the United States, Dr. T. H. D. Griffits, of the Public Health Service, told the Pan-American Medical Congress.

Mosquitos have been liberated aboard transport planes in South American ports and recaptured in North American ports, to prove that the fever carriers can survive flights of at least four days, Dr. Griffits said. He suggested these regulations to prevent the spread of fevers:

Surveillance of passengers and crews of aircraft coming from infested localities; anti-mosquito sanitation at airports and their environs and precautions to prevent mosquito harborage in aircraft and the destruction of the mosquitos found in planes upon leaving airports.

Beware of the small jet-black mole if enlarging or injured, for the growth is the most malignant form of cancer known to science, Dr. Joseph Eller, dermatologist, told a general session of the medical division.

Such growths through their similarity to the common brown mole are generally regarded as of small consequence and are merely cut out and the incision sewed up. Frequently after such procedure the infection carried in the blood stream breaks out in other parts of the body, he said.

When such moles are discovered the safest thing is to cut, with a scalpel or electric knife, a wide ring around the mole, taking healthy tissue with the mole, he added.

Cancer of the lip may be healed by use of radium and x-ray with not even the tiniest scar to show where the growth once existed, Dr. W. S. Lawrence of Memphis told the sectional meeting of the congress.

In 75 to 95 per cent of all cases application of x-rays to the growth will be effective, Dr. Lawrence declared, in relieving patients who have been faced with a misshapen mouth for the remainder of their days.

Coöperation of the United States and Mexico in their common aim of malaria control was the subject of the sectional meeting of international medical relations.

Dr. Miguel E. Bustamanta of Mexico City declared that country is confronted by a severe malaria problem, with 20,000 deaths from the disease yearly out of a population of 16,000,000. Mexican doctors use the same methods to fight the disease as American public health officials, he said.

Dr. F. F. Russell, director of the Rockefeller Foundation, warned against "lumping all malaria diagnoses" under one head. Citing the successful fight of the foundation against malaria in Mississippi, he said that rural education was still the greatest problem in malaria control.

Approval of a "floating congress" aboard a steamer for the next meeting of the Pan-American Medical Association is expected to be given by the association assembly tomorrow. The assembly is the governing body, comprising the official delegate from each chapter, representatives of the nations participating and the executive officers of the association.

The congress would be held in December, 1934,

Continued on Page XX



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MERCK'S LABORATORY DEDICATION

Announcement is made that Sir Henry Dale, Director of the National Institute for Medical Research of England and one of the world's leading authorities on pharmacology, has been selected as the principal speaker at the dedication of the new Merck Research Laboratory, to take place at Rahway, New Jersey, on April 25. Dr. Dale will arrive in this country shortly.

Dr. Dale was knighted in 1932, made Commander of the British Empire (C. B. E.) in 1919, Fellow of the Royal Society in 1914; and, in addition, is a M.A., M.D., and Fellow of the Royal College of Physicians.

In announcing this selection, George W. Merck, President of Merck & Co., Inc., stated that Dr. Dale will be welcomed by the following guests of honor, who have accepted invitations to be present on the occasion of the formal dedication:

Representing chemistry and the chemical industry: Mr. Lammot du Pont, President of E. I. du Pont de Nemours & Co., Inc.; Chairman of the Board of General Motors, Inc.; President of the Manufacturing Chemists' Association.

Representing pharmacy and the pharmaceutical industry: Mr. J. K. Lilly, Chairman of Eli Lilly & Co.

Representing medicine and the public health service: Surgeon General Hugh S. Cumming of the United States Public Health Service.

The State of New Jersey will be represented by Governor A. Harry Moore. Over 300 leaders in medicine and chemistry of the country will be present at the dedication.

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Continued from Page XVII

or February, 1935, centering at Caracas, Venezuela, as the official convention city.

The steamer would sail from New York, touching at Miami, Havana, Panama, Caracas, San Juan, Puerto Rico, and go back to New York.

GEORGE DAVID STEWART

(New York Times, March 11)

In the "Death Song" of Ossian he laments that age was now "on his tongue" and that memory "failed on his mind", but to Dr. George David Stewart, a Nova Scotian by birth, a Scot by inheritance, an American by choice, who now will "soon lie in his narrow house", age never came, despite the years, to rob his tongue of the speech with which he charmed all within the sound of his voice, or to dim his memory of verses, especially of the Scottish poets. He had to the very end of his days that rhythm which he once said every one should have in his soul. That he was eminent in his profession as a surgeon is witnessed by the fact that he was made president of the American College of Surgeons. He was also president of the New York Academy of Medicine at the time when the site for the new building was acquired.

Like Sir Thomas Browne, who could not go to cure the body of his patient but that he forgot his profession and called on God for his patient's soul, Dr. Stewart was concerned for more than the bodily health of those with whom he shared the "common nature" of humanity. He is quoted as saying that "time spent on the knees in prayer will do more to remedy heart strain and nerve worry than anything else," and that the man who does not worship God "at stated and regular intervals fails to get the poise and the self-control which enable him to use all his powers in proper proportion." This is perhaps a part of his Scottish inheritance—at any rate, it was his Religio Medici.

A chair of surgery in New York University, established under an endowment of $1,000,000 by Mr. George F. Baker—a lasting monument of a friendship between the financier and the surgeon—will enable Dr. Stewart to go on teaching by proxy for generations. One can still hear his cheerful answer to the greeting "Hoo' are e'?" —"Brawly" (finely). "Thank ye for speerin" (asking).

MAYOR POTTS RETURNED TO STATE HEALTH BOARD

(Newark Evening News)

Mayor Clyde Potts of Morristown was nominated by Governor Moore as a member of the State Board of Health to succeed Frank S. Tainter of Far Hills, whose term expires July 1. Potts formerly served for a number of years on the board and was its president when he was retired. Other nominations sent to the Senate was Dr. Irving E. Deibert, Camden, reappointed to State Board of Health.

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

County	President	Secretary	Reporter
ATLANTIC	C. H. deT. Shivers, Atlantic City.	John Irvin, Atlantic City	L. M. Walker, Atlantic City
BERGEN	Samuel Alexander, Park Ridge	S. T. Snedecor, Hackensack	C. H. Littwin, Englewood
BURLINGTON	John S. Conroy, Burlington	George T. Tracy, Beverly	Joseph M. Kuder, Mt. Holly
CAMDEN	A. B. Davis, Camden	R. S. Gamon, Camden	Vincent Del Duca, Camden
CAPE MAY	Allen Corson, Ocean City	Eugene Way, Sea Isle City	Eugene Way, Sea Isle City
CUMBERLAND	J. H. Winslow Vineland	E. C. Lyon, Bridgeton	Elton S. Corson, Bridgeton
ESSEX	W. H. Areson, Upper Montclair	Frank W. Pinneo, Newark	E. Le Roy Wood, Newark
GLOUCESTER	William Pedrick, Glassboro	Ralph K. Hollinshed, Westville.	Henry B. Diverty, Woodbury
HUDSON	Louis A. Pyle, Jersey City	B. T. D. Schwarz, Jersey City	Charles Sirken, Jersey City
HUNTERDON	W. E. McCorkle, Ringoes	Barclay S. Fuhrmann, Flem'gt'n	Barclay S. Fuhrmann, Flem'gton
MERCER	William L. Wilbur Hightstown.	A. Dunbar Hutchinson, Trenton	A. Dunbar Hutchinson, Trenton
MIDDLESEX	Robert McKiernan, New Brunsw'k	Samuel Berkow, Perth Amboy	Samuel Berkow, Perth Amboy
MONMOUTH	R. E. Watkins, Belmar	D. F. Featherston, Asbury Park	R. A. MacKenzie, Asbury Park
MORRIS	F. H. Pinckney, Morristown	Albert J. Ward, Morristown	Marcus A. Curry, Greystone P'k.
OCEAN	Abraham Goldstein, Lakewood	Alfred Woodhouse, Toms River.	Eugene E. Herbener, Lakewood
PASSAIC	Joseph Bergin, Paterson	Wayne W. Hall, Paterson	Wayne W. Hall, Paterson
SALEM	William T. Hilliard, Salem	David W. Green, Salem	William H. James, Pennsville
SOMERSET	Thomas Flynn, Somerville	A. F. W. Sferra, Bound Brook	J. L. Young, Somerville
SUSSEX	Leo Drake, Ogdensburg	F. P. Wilbur, Franklin Furnace.	F. H. Morrison, Newton
UNION	Emil Stein, Elizabeth	George W. H. Horre, Elizabeth.	Russell A. Shirrefs, Elizabeth
WARREN	Raymond Wing, Blairstown	L. W. Hackett, Washington	C. B. Smith, Washington

The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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HIS JOB TO BE ALWAYS SICK TO AVOID SERIOUS CASE OF ILLNESS

(Newark Evening News)

Keeping himself more or less perpetually sick, in order to help others keep well, is the strange self-imposed task of Dr. Edward Francis, research scientist of the public health service.

One attack of a disease is enough for most people, but not for Dr. Francis. He deliberately keeps looking for chances to reinfect himself with tularemia, a disease that human beings get from handling infected carcasses of wild rabbits and some other wild animals. Dr. Francis discovered the disease and is leading the search for a cure.

Dr. Francis keeps seeking new tularemia infections because they keep up his immunity against a severe attack of the disease. Such an attack would disable him for three months or more, interrupting for that length of time his studies of the disease.

One serious attack of tularemia makes the victim immune only about a year. A new infection during the period of immunity extends the immunity without making the victim seriously ill. So Dr. Francis welcomes his reinfections, knowing that each one acts as "insurance" against a severe tularemia attack for another few months.

He seeks his attacks of tularemia by constantly violating a rule that all of his laboratory assistants are strictly forbidden to break—wearing rubber gloves when handling the carcasses of infected animals.

Dr. Francis works with bare hands, hoping that a tularemia germ will find its way into his body through some abrasion of the skin. Every so often that happens. Then he has a mild case of tularemia, not disabling, but serving to build up his immunity for another year.

Dr. Francis had his first case of tularemia in 1920, when making his first study of the disease in Utah. He has succeeded in keeping tularemia germs circulating in his blood more or less continuously ever since. They have protected him against further serious attacks through twelve years of research, during which he has added greatly to knowledge of the disease. Almost all that is known about tularemia is credited to Dr. Francis.

Tularemia has been found in all of the United States except New England and in Japan, Russia, Canada and Norway. It is not often fatal, but disables its victims for about three months. Dr. Francis was first to find that it attacks humans, but what might be a warning against it is found in the Bible in a verse in Leviticus, which reads: "The flesh of the hare shall ye not eat and its carcass shall ye not touch; they are unclean to you."

Humans are infected by handling diseased animals, but the animals can be safely eaten when cooked because the heat of cooking destroys the germs.

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BRITON LAUDS WORK OF LATE DR. COIT OF NEWARK IN FIGHT FOR CLEAN MILK

(Newark Evening News, March 22)

Dr. G. F. McCleary of London, retired member of the British Ministry of Health, spoke at the Babies' Hospital, Coit Memorial, at a meeting of the section on medicine and pediatrics of the Academy of Medicine of Northern New Jersey, dedicated to the memory of the late Dr. Henry L. Coit of Newark, founder of the hospital. Dr. Coit died 16 years ago this month.

Dr. McCleary, who is on his way back to England on an Eastward tour around the world, worked with Dr. Coit several times at international conferences on infant welfare. He included a history of Dr. Coit's work in his recently published "History of the Infant Welfare Movement."

The meeting was attended by many physicians and others who worked with Dr. Coit in his fight for clean milk which resulted forty years ago in the first production of certified milk, now recognized as the standard of clean, raw milk in many countries. It was on this phase of Dr. Coit's work that Dr. McCleary dwelt in his tribute.

"Coit's contribution to the initiation and advancement of the infant welfare movement was of great importance," Dr. McCleary said. "From Paris came the development of the infant welfare consultation center; J. W. Ballantine in Edinburgh gave emphasis to the ante-natal factor; Coit taught us that more attention must be given to infant feeding, made us realize that we must improve artificial feeding in the face of opposition from old school physicians.

"The certified milk movement served to define the standard of clean milk, it formulated action to obtain conformity with this standard and set up an organization to put the thing into effect."

The speaker recalled his first meeting with Dr. Coit at a conference in Brussels in 1907, after which Dr. Coit visited him in England. The originator of the certified milk movement at that time, he said, put greatest emphasis on the fact that it was a professional affair, not one to be placed in the hands of public health authorities.

"The movement has lived and grown and spread," he said, "like the ripples from a pebble dropped into a pond. Even today in the cities that require pasteurization of all other milk, certified milk is the only exception. This I call a very great compliment."

The movement, Dr. McCleary declared, did far more than make certified, clean, natural milk available for infants and invalids—it served to raise the general standards of milk throughout the world and emphasized the possibility of the influence of the medical profession.

"The influence of medical men in public affairs has grown—in England at least—for the last twenty years. Formerly this professional influence was limited largely to members of the legal profession, but I feel that as we learn more of the nature of the human body and the human mind the physician, the repository of this infor-

Continued on Page XXIII



APPROACH

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F. H. BARNES, M.D.,
Med. Supt.

Continued from Page XXII

mation, will be called upon more and more to aid in the affairs of state.

"As far as I know Coit held no public office, but his influence on public health has been great in this country and throughout the world. He was an unusual combination of tenacity of purpose and dynamic power with a lovable humanity. The effect of his vision will be felt in the future even more than it has been in the past."

Dr. McCleary was introduced by Dr. Frank W. Pinneo, secretary of the Essex County Medical Society, who arranged the meeting in coöperation with Dr. Charles F. Rathgeber, chairman of the academy section. Dr. Pinneo and Dr. Elmer G. Wherry, medical director of the hospital, spoke briefly of Dr. Colt's work and influence.

UNIVERSITY OF PARIS HONORS DR. CUSHING

(New York Times)

Dr. Harvey Cushing, noted American surgeon, was one of five foreigners named by the University of Paris to receive the degree Doctor Honoris Causa, whose selection was approved recently by the Ministry of National Education.

Dr. Cushing, internationally known brain specialist and neurological surgeon, has been a recognized leader in medical research and practice for more than twenty years. He has been honored by universities, governments and medical societies all over the world and a list of his former patients would include many of the most celebrated contemporaries of the two hemispheres.

Since 1912 Dr. Cushing has been Professor of Surgery at Harvard and surgeon-in-chief at Peter Bent Brigham Hospital in Boston. He was for ten years Associate Professor of Surgery at Johns Hopkins.

He was born in Cleveland on April 8, 1869, graduated from Yale with a Bachelor of Arts degree in the class of '91 and four years later received both his Master's and medical degrees at Harvard.

The author of a number of books on medical subjects and a frequent contributor to medical journals on subjects relating to neurological surgery, Dr. Cushing some years ago turned to the biographical field winning the 1925 Pulitzer Prize for the best American biography with his two-volume work, "The Life of Sir William Osler". It remains his only venture into a form of writing which is not concerned with specialized knowledge or technical subjects.

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PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 5 Orange, N. J., May, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

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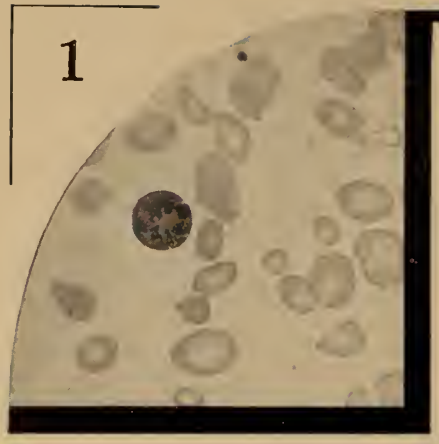
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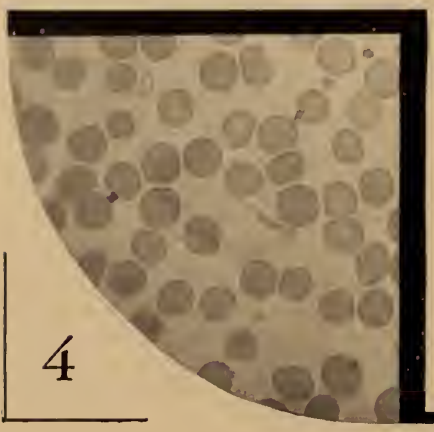
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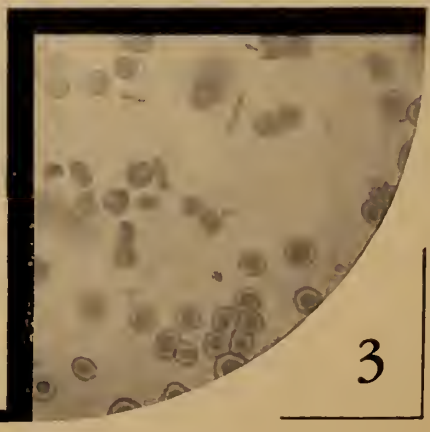
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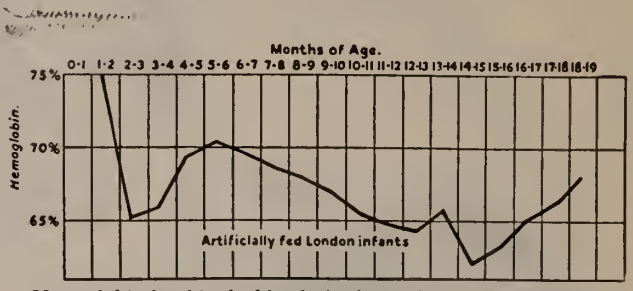
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Hemoglobin level in the blood of infants of various ages. Note fall in hemoglobin, which is closely parallel to that of diminishing iron reserve in liver of average infant. Chart adapted from Mackay.[1]

Anemia Prevalent

Commenting on this work, the British Advisory Committee on Nutrition writes, "This form of anaemia is prevalent among infants, especially those living under conditions of city life, and is attributed to a deficiency of available iron and possibly also of copper. Its most important feature is susceptibility to infection, particularly a liability to colds, otorrhoea, bronchitis, and enteritis, and a tendency for infections to become chronic."[2]

Iron, incorporated in powdered milk, should be given as a routine to bottle-fed infants, according to the recommendations of this committee in a report to the Ministry of Health.

Milk Deficient in Iron

Stored in the liver of the full-term infant is a supply of iron and copper theoretically sufficient for the first six months of life. But actually the reserve is subject to wide variation, probably because of (except in the case of prematures and twins) variations in the iron content of the mother's diet during pregnancy. Hill, for example, says, "If the mother is anemic herself, or if she has eaten little iron-containing food during the last months of pregnancy, her offspring is born with an insufficient iron deposit. . . ."[3]

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* The desirable iron intake for children according to Rose *et al*, is 0.76 mg. per 100 calories. Infant of 1 month (8¼ lb.) and infant of 3 months (11¼ lb.), both require 50 calories per lb.[6]

[1-6] *Bibliography on request.*

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Vol. XXX., No. 5 ORANGE, N. J., MAY, 1933 Subscription, $3.00 per Year
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THE GENERAL PRACTITIONER, HIS RESPONSIBILITIES AND PROBLEMS

John C. McCoy, M.D.,
Paterson, N. J.

Whatever may be the scheme or plan for the *practice of medicine* in the future, it must then, as now and in the past, give due consideration to the *Art of Medicine.* An individual requiring the attention of a physician will not be satisfied with machine, technocratic, or mass methods of approach and treatment. It is the *personal relationship* (attitude and contact) between physician and patient, which is, in my opinion, the most vital factor in the care of the sick. It matters not what the method may be, nor whether it be directed by the individual physician, the group of physicians, the clinic or a larger hospital organization—if the outcome is to be satisfactory to the person requiring medical care—there must be, on the part of the patient, a feeling of confidence that he will be treated as an individual entity, and receive scientific, capable, intelligent and sympathetic consideration. In these days much has been and is being written and said relative to the decline, and even the eventual elimination, of the "general practitioner", or the "family physician". We have seen the development of new cults, and various forms of practicing the healing art, which at times seemed quite revolutionary as compared to the methods of years ago. Social conditions have changed, of course, and as the result of those social, industrial and economic changes, medicine has assumed a different attitude toward society, and, we must learn to appreciate the fact that the practice of our art is subject to the same laws of nature as influence economic conditions in general.

Has the "general practitioner" been alive to changes taking place, and has he availed himself of the facilities placed at his disposal to so equip himself, as intelligently to meet the altered conditions, and bring to his patient the type of service which the layman, through popular reading, has learned to expect and demand? What with the natural and normal advance of scientific medicine, the general practitioner has apparently developed an inferiority complex, due perhaps to the present passion for specialization.

Dr. Bernard Sachs said, in his address as President of the New York Academy of Medicine, this month—"The general practitioner, the man with broad vision, calm judgment, and human touch—the family physician—with a full appreciation of the needs of the individual, under the present strain of social and economic stress, is sorely needed." Referring to this address, the New York Times of January 7, 1933, said editorially, quoting from the Lowell Report on Medical Education: "Changes in medical practice have not and cannot modify the essential unit of medical service and training, which is the patient, and that the unchanging patient is a sick and, therefore, an unduly sensitive human being. What the head of a family wants in a doctor is a thoroughly trustworthy friend who will take the members of the family under his remitting care when they need it;

and not an expert inspector, who will refer each of their separate ailments to a different high-priced stranger for impersonal treatment."

It has been said that 40% of the graduates of Medical Colleges now become specialists and, according to the Lowell Report, half of these have had no experience in general practice. The reason for this, as the report states, is apparent; i. e., specialization is easier and more profitable.

Such idealistic and altruistic views as Dr. Sachs has expressed, will probably have the support of medicine at large, but, to accomplish the same the layman must convince the family physician that these sentiments are his, and the laity must be willing to compensate the family physician for such services.

The best interests of the public will be, as they always have been, conserved, so far as health is concerned, by a capable medical profession. The practice and art of Medicine, if it is to interest our younger men and draw into the ranks men of high character and capability, must assure them the possibility of a life commensurate with that of other professions.

It is estimated that 70-80% of the practice of medicine can be, and probably is, done in the home or in the physician's office; which should presuppose an intelligent, well-rounded general practitioner, capable of directing his patient so that proper and available means may be honestly advised for diagnosis and treatment. The respect and confidence of society for the general medical profession depend upon its interest in and devotion to individual members of the profession. The standards and ideals of a community are only those of the individuals composing that community; the ethics, culture and humanities of its hospitals and educational and civic systems, will be but the reflection of those entrusted with their direction and administration. The spirit of commercialism has, naturally, touched the medical profession, as it has citizens in all other walks of life. The medical man would not be human, if this were not the case, but there remains in the rank and file of the profession a sense of responsibility and an inherent desire to serve, regardless of compensation and remuneration. We, therefore, cannot entirely agree with the statement made by Dr. Morris Fishbein: "There has been a great advancement in the technic of medical diagnosis and medical care. In modern scientific medicine, *the old-time doctor,* who made a diagnosis on the basis of the history of the case, a look at the tongue, a record of the temperature, and a brief touch to the pulse, has no place. Today the microscope is familiar to every student of medicine, although he may not have complete facility in its use. The confident practitioner realizes the qualities that lie in proper employment of the cystoscope, proctoscope, electrocardiograph, and technic of blood chemistry. With the coming of greater exactitude has also tended to come, *the coldness* that seems to be the inevitable accompaniment of the introduction of the machine of industry."

This may be so, but if the physician was able by careful powers of observation to study more in detail the character of the tongue as an index of certain definite disease processes, and could at the same time, through practice and observation, make proper deductions from the type of the pulse, he might be able also to obviate certain errors in diagnosis. Certainly, during the unpleasant period through which our country, with all others, has passed during recent years, the machine age of industry has failed to bring us that degree of peace and general comfort to which we, as a people, had looked forward. The marvelous strides of medical education toward scientific medicine during the past 3 decades must be fully appreciated by one who has been a member of the profession during this period. Certain diseases have been brought definitely under control, and others will be, undoubtedly. It has been difficult for the general practitioner, with the arduous duties imposed upon him in his home community, and the demands upon his time for welfare and uplift work, to keep fully abreast with scientific advancements but, in general, he has practiced his profession, art, and philosophy, in an intelligent and conscientious manner, as did a host of his predecessors, leaving the place of his labors, and the world at large, better as the result of his efforts.

The general practitioner, through his intimate knowledge of those under his care, has a contact and influence vouchsafed to no other individual.

Dr. E. Starr Judd, in his Presidential Address before the American Medical Association, June 9, 1931, said: "The individual relationship of the physician and the patient is now, and always will be, the crux of medical practice. The fact that several plans for public relations have been worked out and put into operation, shows that the profession is aware of the social and industrial changes and is fulfilling its obligations. * * * With all of this development, however, unless the intimate personal relationship between physician and patient is maintained, it will not be possible to obtain for the patient the kind of service to which the majority of American citizens are entitled and will demand. One thing I am certain of is, that whether caring for the sick is done by private practice, group practice, clinic or guild, it must be continued on a personal basis. Routine procedures, with established compensation and reward, would not only destroy all enthusiasm for development of the art of medicine, but would also take away all stimulation and initiative for investigation and research."

We must not, as members of the profession which for centuries has given its best endeavors to the prevention of disease, forget that the glamor of huge "medical centers" will not supplant the pains-taking, conscientious and sympathetic services of the individual physician. That great teacher, Dr. Frank Billings, of Chicago, said: "Too often, the necessary primary fundamental physical examination is not made, or is not made as thoroughly as it should be. Over and over again, an erroneous diagnosis is made on the basis of laboratory findings, which would have been avoided, and the correct diagnosis established, by available simple methods of examination. * * * Based on a long experience in general hospital and private practice, it is my opinion that a correct anatomic and functional diagnosis can be made in 80-85% of all patients in an average community, by a qualified, industrious, pains-taking general practitioner, by the sole application of the trained mind, the special senses, the hands, and an always available simple laboratory equipment."

During the period of our industrial life many changes in medical practice have been forced upon the physician, have interfered with his economic standard of living, and have resulted in an insufficient remuneration and reasonable comforts for himself and his family. The progress of medical science during the past 50 years was due largely to men who, after a well-balanced career in the profession, devoted their efforts to some special branch of medicine. The compensation, in recent years, for specialist's services has not always seemed to be just and commensurate with services rendered, and there has been a marked discrepancy in their monetary returns, as compared with those of the general practitioner. This accounts for the ever-increasing number of younger men who, without a broad and thorough practical education in the art of medicine, soon confine their attention to a special line of work.

Is not a general and practical knowledge of the medical art, for a certain period of years, an essential pre-requisite to practice of a specialty?

There should be, also, a proper legitimate honest understanding between the specialist, the general practitioner, and the layman. The physician's part should be more than acting simply as a "clearing house" between the specialist and the patient. If the laity demands, as its trusted medical adviser and friend, a physician capable of recognizing when a pneumonia eventuates in empyema, and when an abdominal colic is due to a diseased appendix or a perforated gastric ulcer, it should also be taught to appreciate the fact that the ability to recognize that condition is just as important a life-saving measure, as the glamor incident to the surgical intervention which may cure the patient, and that the physician is entitled to proper recognition.

Contract practice, with all it involves, is probably one of the outstanding factors which have interfered with the physician's relationship to the community. It was started by well-intentioned individuals and groups to safeguard the welfare and improve the conditions of cer-

tain classes in the community, deprived of specialized medical attention. It was a result of the tremendous trend in specialization and the prohibitive charges which the average individual was called upon to meet. Like other so-called uplift movements, contract practice, in one form or another, has permeated every field of medicine, and has compelled the physician to either indulge in contract work or compete with contract practice groups controlled and paid by industrial corporations, insurance companies, State, County and Municipal institutions. We recognize the good which has been accomplished by it but, as now expanded and promiscuously carried on under political and lay supervision, it has certainly divorced the patient from the physician of his choice. Witness the expansion of State, County and Municipal institutions with overhead charges to be paid by the taxpayer, including the physician, which are manned by full-time paid employees, upon many of whose advisory boards are physicians who give their time and labor without compensation. Many of our corporations deemed it expedient to employ physicians in their industries, and some others have gone further still and insisted upon medical and social-service inspection and supervision of the families of their employees. There is no question but that each new invention and development in our industrial life has created new conditions in sanitation and health, which have to be met by, both, laymen and physicians. The layman has looked to the medical profession for leadership in these movements.

Inherently, contract practice is unjust and unethical. It interferes with the right of the individual to employ the physician of his choice, and compels the physician chosen to render services at such low compensation as to interfere with efficient and personal medical care. As Dr. Leslie L. Biglow said (Int. Med. & Surg., January 1927): "Insidiously and slowly, without appreciation of their ultimate effect on medical practice, by their often well-meaning but thoughtless sponsors, or boldly and with deliberate intent to work quickly a revolution, certain movements have been allowed to gain headway, which, if unchecked, would surely lead to *state medicine* or socialization of medical practice. What may we expect from this revolutionary change in the status of the medical practitioner, when he ceases to be an individual and becomes a mere unit in the new army of government employees, with the consequent abrupt shift in his allegiances and loyalties?"

On November 29, 1932, the Committee on the Costs of Medical Care completed its 5 years of study and made its "Final Report". Almost $1,000,000 were spent in this study, and yet one is forced to the conclusion that the "majority recommendations" will lead to still further expansion of contract and insurance practice and, in the end, to socialized or state medicine.

An editorial in the Journal of the American Medical Association, Dec. 3, 1932, states: "Briefly, the 'majority report' recommends that medical practice be rendered largely by organized groups associated with hospitals, and expresses the hope that these groups will maintain the personal relationship between patient and physician, so essential to good medical care. Such practice has, moreover, on various occasions had the endorsement of representatives of some of the 8 Foundations that contributed to the financial support of this Committee. In contrast with those recommendations, the 'Minority Report' recommends that united attempts be made to restore the general practitioner to the central place in medical practice. This it does with good reasons, for experience has shown that more than 80% of all the ailments for which people seek medical aid can be treated most cheaply, and most satisfactorily, by a physician. The expensive studies and investigations conducted by the Committee have not disproved this fact." The "minority report" further states: "It seems clear that recommendation for further trial and expansion of voluntary insurance schemes in the United States is entirely inconsistent with the Committee's own findings. Voluntary insurance schemes are now in operation in many parts of the United States, and increasing in number and size. In many places these schemes are being operated in accordance with the plan recommended by the majority of the committee, that is, by making contracts with organized groups of the medical profession. That

they are giving rise to all the evils inherent in contract practice is well known. Wherever they are established there is solicitation of patients, destructive competition among professional groups, inferior medical service, loss of personal relationship of patient and physician, and demoralization of the profession." The minority also recommends: "That the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed, as being economically wasteful, inimical to a continued and sustained quality of medical care, or unfair exploitation of the medical profession."

Surely we have had a rather pathetic demonstration from the administration (or lack of same) in the Veterans Bureau of what would be the status of the medical profession paternalized.

If the Federal Government continues in liaison with the World War Veterans, assuring hospitalization and medical care to all veterans, regardless of the fact that their disabilities, in a gradually rising percentage of cases, cannot, by any stretch of the imagination, be attributed to military service; we may soon have other organizations, which are just as logically entitled to free hospitalization and medical care, demanding the same, and social or state medicine may with all its attendant evils be a fact in the not distant future.

As one who served with our Army over-sea, I believe it should be considered a sacred privilege to serve one's country. Our citizens should not be forced to pay tribute to those who returned unscathed. It is the duty of every citizen of our government to protect and care for, in an intelligent manner, any one who as the direct result of military service has been disabled by injury or disease, but there should be no reward or bonus for performing one's duty; otherwise, *patriotism* is a misnomer. The Veteran's Aid since the War has reached well over $6,000,000,000. The Act, as drafted and amended, is unpatriotic and selfish, having increased the suffering of many service men, who are now in the "Army of the Unemployed". Such wanton medical legislation pauperizes the recipient and lowers the standard of medical practice; thus we find the Federal Government fostering *state medicine* and *contract practice,* and entering into competition with the medical practitioner and established hospitals in the country. Most, if not all, Veterans legitimately disabled in military service, could be efficiently cared for in hospitals now in existence, and thus eliminate the tremendous cost of additional institutions, and the ever-mounting overhead and political maintenance of same.

This huge pains-taking and thorough investigation of the Committee on Medical Costs should be of vital interest to the medical profession and to the laity, as well. As a matter of fact, upon the basis of the report, the physician's fee is by no means the greatest item in medical care. We believe the cost of medical care can be lowered not by State control or socialization of medicine, thus placing it under politico-philanthropic influences, nor by group, guild, or Soviet methods of practice; but, by an intelligent education of the laity. There must be: on the part of the public, an appreciation of what their demands call for, in an educated, well-rounded, pains-taking, medical practitioner, willing to devote his best endeavors to the interest of the individuals and the family; and, on the part of the layman, an inclination to set aside each year a sum, in his budget, to meet the emergencies incident to sickness, and thus be able to maintain his self-respect as an American citizen, and not be forced as a result of improvident living and spending (usually on the instalment plan), to accept impersonal machine-made medical attendance, which will from lowered morale and lack of individual interest on the part of the insurance-paid group or industrial guild, render service commensurate only with what he pays. There has been no apparent evidence on the part of physicians to default as regards personal consideration for persons in their respective communities who have been unable to meet the expenses of medical care du recent trying years. They have given of their time and means to assist in caring for the sick and unemployed, with no expectation of compensation.

If it is for the best interests of all that communistic methods be applied to our social life, why confine it solely to the profession of medicine? When clergymen, lawyers, and

business men, from an insatiable desire to benefit humanity, decide that the best interests of society will be conserved by the adoption of group or guild methods as to their professions, and the application of such methods are to be general, we feel sure that the medical profession will be ready to change its attitude.

The medical profession should, however, now awake to the problems of socialized medicine which confront it, and develop an intelligent understanding of the situation now existing; for, if the profession does not present a united front in combating the insidious power this "Octopus" is exerting in well-nigh every community in our land, legislation will be enacted by laymen and politicians which will retard the advance of scientific medicine.

This seems to be an era of commissions instituted by apparently well-intentioned individuals to investigate conditions relative to our social, political, industrial, economic and personal lives. We have, during the past decade, been under that noble experiment—"Prohibition"—which has undone much of the sane educational work of the preceding decade, relative to the use and abuse of alcohol, and created a lack of respect for law, in general. Shall we, by sudden revolutionary methods, disturb the relationship between patient and physician which has existed for centuries and been partly responsible for the advance which scientific medicine has made during the past 50 years? Changes will occur in medical practice in the future, as in the past. Such changes will be essentially fundamental, and not of such a radical and socialistic nature as to disturb the faith of physicians who have been loyal to the ideals and ethics of their profession.

We recognize the fact that medical services of a proper character are inadequate in many of our rural districts, and in centers of population are often not so adjusted as to meet the requirements and demands of the public, and safeguard the best interests of the people and the practitioners. In every community where a hospital exists, an earnest effort should be made by those entrusted with administration to evolve plans looking to the hospitalization and care of patients of moderate means. These are the individuals who, in every locality, comprise our best citizens, and are the "back-bone" of the community. They do not want to lose their self-respect, or become pauperized; nor should they be forced to the expenditure of sums of money entirely out of proportion to their ability to pay. These members of the community should be assured by an interested hospital administration that they will receive proper and efficient hospital, medical, surgical, and special services commensurate with their income and ability to pay without entailing severe hardship. The hospital should supply a scheme of nursing, covering all types of private patients, to meet the requirements and demands of the average patient, and not subject him to the additional expense of special nursing, save in exceptional instances. This presupposes a hospital administrator of broad vision, the human touch, and a desire to serve every patient entering the institution. Whatever may be the changes contemplated in the plan and scope of medical practice, judgment should not be unduly influenced by the social and economic conditions of the past few years; there should be a quiet and unbiased exploration by all parties concerned. Such an investigation should precede the adoption of any program anticipating a change in the relationship between the medical profession and the public. No satisfactory solution, to either the public or the profession, will be accomplished unless directed by the medical profession considering primarily the best interests of the individual patient.

I have only touched, and in a cursory manner, upon a subject which has occupied the attention of many able minds during the past decade. I am not pessimistic nor anxious as to the future of scientific medicine, nor as to the art and philosophy of our profession, nor am I disturbed as to the future of the medical practitioner adjusted to our social and economic structure; but I am not ready to trust the well-being and health of our people in the hands of the politician or the well-intending layman, to dictate the policies of state or socialized medicine. What will be the character of men who will enter the profession under such circumstances, and what will be the type of medical service vouchsafed our citizens,

with supervision of the medical profession subject to the whims and changes of political parties? Let us have faith that the best traditions of our profession will prevail, and the ideals and ethics of its individual members will be maintained, and thus assure the public our sympathetic, conscientious and efficient medical care.

TEN YEARS WITH THE MATERNAL WELFARE COMMISSION OF ESSEX COUNTY

Walter B. Mount, A.B., M.D., F.A.C.S.,
Montclair, N. J.

In May, 1923, almost 10 years ago, when Dr. Mitchell was President of the Essex County Medical Society, he was persuaded by Dr. Theodor Teimer to appoint this Commission as a committee of the County Society. Dr. Teimer conceived the idea and is the real father of the organization. He realized it was needed, saw its possibilities and cherished it through all its early years as its first President. Its object is the promotion of maternal welfare: (1) By raising the standard of obstetric practice in the community; (2) by coordinating all existing agencies for the care of maternity cases; and (3) by teaching the public the vital importance of adequate maternity care. The Commission was constituted a separate entity, worked out its own Constitution and By-Laws and was given great freedom of action.

Some facts about the medical and obstetric situation in Essex County may be of interest. Essex County has, of course, the largest population of any County in New Jersey, and Newark is the largest City in the State, with a population of 443,000. There are 25 communities with a population of 808,500. The 31 hospitals contain 6751 beds, of which 581 are obstetric beds. East Orange with 68,000, and Orange with 36,000, are the other two cities in the county. These 3 cities have 14 hospitals accepting obstetric patients, and 462 obstetric beds. The 6 towns with a population of 211,000 have 5 general hospitals with 119 obstetric beds. There are 9 boroughs, 1 village and 5 townships. There are 3 County Hospitals and 3 Convalescent Hospitals with 3500 and 110 beds, respectively. There are also 6 special hospitals. In the County there are more than 1100 physicians, of whom 800 are members of the County Society and 420 are members of the Academy of Medicine of Northern New Jersey. Compare this County with the neighboring Bergen County and you at once see the difference in our problems:

TABLE 1

In Essex County		*In Bergen County*
25	Communities	60
808,500+	Population	301,558
31	Hospitals	7
19	Hospitals accepting obstetric cases	3
581	Obstetric beds	100
6,751	Total beds	1,143
1,105	Physicians	334
800	Members of County Society	221

Twelve active members were appointed by the President of the County Society to serve for 3 years in rotation; 6 active members have been re-appointed, again and again; one of these died—the late Dr. McCormick—but 7 new active members have been appointed. Of the original active members, 3 have been made Honorary Members—Drs. Edward J. Ill, Mitchell and Teimer. There is 1 ex-officio member, the Health Officer of Newark, as he was 1 of the original active members. There are 40 associate members, including the 21 Health Officers in the County. At one time postcard notices were mailed monthly to 60 associate members, very few of whom attended. Now notices are sent to associate members only once or twice a year.

Meetings were held monthly until 1927; since then there have been only 5 each year. This change made the meetings more spirited and business-like. No records are available for the first 2 years, during which time the Secretary was often absent from meetings. In the 8 years since 1925, 54 meetings have been held, most of them in the building of the Academy of Medicine of Northern New Jersey. The average attendance at each meeting has been between 7 and 8 active members and

*(Read before the Woman's Auxiliary to the Essex County Medical Society at the Academy of Medicine, Newark, N. J., January 23, 1933.)

more than 3 others. There have been meetings with health officers, hospital superintendents, parent-teacher associations, The Section on Obstetrics and Gynecology of the Academy of Medicine of Northern New Jersey, and the Woman's Auxiliary of the Essex County Medical Society.

Many matters have been discussed at our meetings. Often it seemed as though progress was slow, accomplishments meager, and time perhaps wasted. The various committees did good work. When the chairman of a committee could not attend a meeting, he would try to have someone else on his committee make the report, but sometimes the chairman was the only one who had any knowledge of the situation. These committees have been: (1) Pre-natal; (2) Hospital; (3) Educational; (4) Follow-Up; (5) Statistical; and (6) Finance.

One of the first accomplishments was that pre-natal work was standardized. It was centralized in each community. Over-lapping of effort was abolished. Pre-natal cards were printed and used, especially by nurses in recording the blood pressure, urine examinations, etc., on their visits to the patients between clinic visits. These same pre-natal cards were furnished gratis to physicians through the Boards of Health. For each city where necessary a central Maternity Bureau was established.

In certain hospitals the percentage of patients delivered who had adequate pre-natal care rose in these years from 10% to 16%, 33% and even 64% by 1930.

The maternal death rate for Newark was:

In	1926—6.1	per	1000
"	1927—6.6	"	"
"	1928—6.2	"	"
"	1929—4.9	"	"
"	1930—5.8	"	"
"	1931—3.3	"	"

Standard obstetric record sheets for hospital use were devised after many conferences. Based largely on those used at Orange Memorial Hospital, their main virtues are simplicity and brevity. Long histories and physicals we found written up less frequently both by interns and by physicians in charge of private patients. Additional data could always be added for any complex case. After certain suggested changes had been made, these record sheets were approved by the American College of Surgeons, and we feel they are far superior to the record sheets they favor. The use of the same record sheets in all of a group of hospitals has obvious advantages, especially in the matter of comparative results. We are all speaking the same language. The name of the particular hospital is added in each case. These records are printed in Newark, New Jersey, at a cost of $5 per 1000. Some hospitals use only some and not all of the set of record sheets.

A yearly obstetric report from all hospitals was begun in 1926. A special summary card is filled out for each patient on her discharge from the hospital. Dr. Carl H. Ill has had charge of this splendid report each year. His paper, published in the American Journal of Obstetrics and Gynecology for July, 1931, shows many interesting facts. Too many cesareans were being done in some institutions—5.65% in one hospital, 4.99% in another. The maternal death rate following cesareans was 7.6% as compared with a general rate of 0.5%. The general fetal death rate was 2.7%; following cesarean it was 7.23%. Where eclampsia was the indication for cesarean, the maternal death rate was 2.8%. In the 85% of eclampsia patients not operated on the death rate was 1.3%. Cesarean operation for toxemia gave a death rate of 18.2% against less than 1% in 20 times as many patients treated conservatively. This paper covered the years 1927 to 1929.

In 1931 there were in Newark 10,052 births:

Maternal deaths	33 or	0.33%
Fetal deaths	233 or	2.3 %
Still-births	350 or	3.48%
Cesareans	218 or	2.17%
Maternal deaths	4 or	4.5 %
Fetal deaths	24 or	11. %

These reports are still being obtained each year.

Seven papers were written by 4 of our members; all on obstetric subjects; 5 published between 1925 and 1930, 1 of them being published and distributed at our own expense. One of our early ideas was that such papers should be read at our meetings, approved and then published. All but 3 of these papers were

written by men who at the time were associate members. Among the topics were: An Analysis of Obstetric Work Done in Essex County for Three Years. Obstetrical Routine in Orange Memorial Hospital. The Work of the Medical Commission for Maternal Welfare of Essex County, New Jersey. Transfusions in Obstetrics. Treatment of Eclampsia.

Members of the Commission have also explained its work in other counties.

Many obstetric lectures have been sponsored by our group. For many of the worthwhile talks given before various societies in the county, extra post-card notices were sent to non-members interested in obstetrics or gynecology. This was done by a checking-off of the membership lists of organizations in the Medical Directory and then eliminating doctors doing other work. Often these notices were sent to men outside of our own county, and always to the hospitals. There followed an increased attendance at meetings addressed by such well-known specialists as Drs. Eliot Bishop, George L. Brodhead, Frederick C. Holden, Frederick C. Irving, George W. Kosmak, Emil Novak, Edmund B. Piper, the late John O. Polak. Irving W. Potter, Frederick W. Rice. I. C. Rubin, Henry H. Rusby, H. J. Stander, Paul Titus, Benjamin P. Watson and Hervey C. Williamson.

In 1929 an attempt was made to determine the work of the physicians in Essex County. For 1105 postcards mailed, 486 replies were received, or 44%. Of this number 45% were doing no obstetrics and 42% were doing obstetrics with other work. Forty-seven (9%) stated they were specializing in obstetrics and gynecology. There were 10 specialists in gynecology only, 3 in obstetrics only, and 2 "consultants" in obstetrics only. Eighty-five delivered patients either in hospitals or at home, 75 in hospitals only, and 4 only at home. Today there are 9 specialists in obstetrics in Essex County.

In 1929, a drive for better obstetrics in Essex County was carried out; 7 obstetric meetings were held in 7 weeks by the 9 medical societies in the county. These were widely advertised and well attended. "Maternal Aid" was splendidly covered by Miss Mabel Corbin, Director of the Maternal Health Center of New York City. Other subjects were: Ovarian Pain—Pre-natal Care—Repair Work Following Labor—Three Types of Uterine Bleeding—Toxemias of Pregnancy.

About $247 was spent on this drive, largely for printing, postage and secretarial work.

In 1930-1931 the Commission sponsored an excellent course of 7 lectures in obstetrics by Professor Watson and his Staff from the Sloane Hospital for Women; $10 was charged, and there were 92 paid admissions and many others, for interns and nurses were not charged. Three hundred dollars was asked but $550 was paid to the speakers. No course of the Rutgers University Extension has been more popular and probably none better given. We believe that such a course can best be given by the teaching staff of a single institution; in this way the subject matter is better presented and there is no overlapping.

The balance remaining from this course was offered to the Essex County Medical Society, but was not accepted. Part of it was used to procure dark shades for the auditorium of the Academy of Medicine in Newark, where our meetings had been held, so that pictures could be shown in the afternoon. The balance is being used to pay a special investigator to follow up all cases of maternal deaths.

For many years our Follow-Up Committee had been attempting to get information about maternal deaths. After much discussion a special form had been printed and was mailed to each physician who signed the certificate in a case of puerperal death. The information as to the name of the patient and the name of the doctor was supplied by the Health Officers. The Health Officers of Newark and some other communities coöperated very well; others poorly. Physicians filled out the form incompletely and in many cases not at all, even after a second request.

Therefore, in 1932 the advice of the New York Committee investigating maternal mortality was followed and a paid investigator was used all that year, who interviewed the physician, saw his record and the hospital chart, and filled out the form used in New York City and in other regions, a form furnished by the United States Department of

Labor. The investigator, who is a physician with tact and obstetric training, receives $5 for each case investigated. This has been paid from the balance left over from the Sloane lecture course of 1930-1931; to date $231 has been paid.

This was already in the mind of Dr. Teimer as one of the main objects of this Commission and now, after a number of years, he has the satisfaction of seeing progress made along these lines. Our conclusions from these reports are not yet ready.

At one time efforts were made to have further information obtained on still-birth certificates. Dr. Craster has talked this over with authorities in Washington and with other health officers but nothing has been done as yet.

An attempt was made to control criminal abortions. Conferences were had with the County Physician and with the County Prosecutor. The main trouble was the difficulty of obtaining convictions.

It was urged that in all therapeutic abortions (usually in hospitals), 3 instead of 2 physicians see the patient and record their opinions in writing.

The midwife situation is interesting. In 1919 there were in the City of Newark 450 midwives who delivered 30,000 women. In 1925 16,000 patients were delivered by 387 midwives—a decrease from 66 to 41 patients for each midwife. Talks to the midwives have been given by members of the Commission.

You may wonder about our financial status. The Finance Committee hoped for a grant of money but never obtained it. We took in $910 from a lecture course; after all expenses were paid we had over $300 balance. Dr. Bingham received $50 from "Charm", the magazine published by Bamberger & Co. of Newark, for one of his articles they accepted; this sum was turned over to the Essex County Medical Society. This parent organization has nurtured us well and paid all bills presented to them. In 1929 the drive for better obstetrics cost them $247. In 8 years they have been responsible for $659.68—$365 for printing, postage, etc.; $262.77 has been paid an assistant secretary, who does much of the routine work; and the expenses of the secretary for postage and supplies have been $31.91. Today these expenses might well seem extravagant and economy is in order. The assistant secretary is to have his stipend of about $30 a year considerably reduced. No stationery will be necessary for a number of years. Several years ago the names of the officers of the Commission were omitted from the stationery so that it would be available from year to year in spite of the changes in officers. Especially do we desire to continue the work of a paid investigator to follow up puerperal deaths.

The fellowship and companionship developed in such an organization and the discussion of our problems amply repay the time spent.

Lastly, in June, 1932, at the Annual Meeting of the New Jersey State Medical Society, President Hagerty appointed a State Committee on Maternal Welfare, which held a meeting forthwith and had another meeting on December 1, 1932, in Newark. Under this Committee's supervision, Commissions for Maternal Welfare have now been appointed in all the 21 counties of the state. About 30 members attended the December meeting. Meetings of these County Commissions are being planned for twice a year—one of them at the State Meeting in June.

We believe the Essex County Commission for Maternal Welfare to be the first commission of its kind in the country.

TRUCE

By Geoffrey Johnson

Let us be cowards a little and not climb
  Forever the topless heights that soar so cold
  Among the stars: for we too early-old
Shall die, and gleams of the unreached sublime
Tinge but our dying eyes. No human hold
  Can hurl Death's dark strong angel from the mind.
  We touch impassable secrets like a wind
Eternally weary round the peaks untold.
Let's to the valley: we are gray and hard,
  Our souls with age-deep thought are glacier-scarred,
But Earth is warm and human in the plain.
  There, once more children, let us make our nests,
Sleep in the shadows of her hillock-breasts,
  And drink the milk of wisdom-without-pain.

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

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A NEW ERA—A NEW DEAL

Since as far back as we can remember, the medical profession has been "facing a crisis" of some sort, and the present moment, that of preparing for the 167th Annual Meeting of the Medical Society of New Jersey, is not for us exceptional as an occasion for using that phrase. If there be a difference this year, we would say that it will be found mainly in the fact that the stated phrase is at this moment more than usually appropriate. Early in December 1932, when issuing a call for our autumnal session of the Tri-State Medical Conference, we happened to say that "the end of one era is but the beginning of another"; meaning simply that the transition period is of such brief duration as to pass, ordinarily, unnoticed. It was at about that date, however, when the entire nation began to realize the true significance of the so-called depression; began to understand that we had been experiencing something of unusual character and greater import than a financial cataclysm (serious as that feature of it was) and that the *depression* was an *effect* rather than a *cause*.

The practice of medicine was not exempt from this general evolution in our social and political life. In its case, evolution has been hastened by publication of the Final Report of the Committee on the Costs of Medical Care.

It has been interesting to watch the course of events since that Report was made public. Anticipating some such suggestions as were made by the Majority, a speaker at one of our Tri-State Conferences more than 2 years ago said, in effect: Faced by such a situation, we, the medical profession, may ignore the demands made, asserting that outsiders have no right to interfere with our conduct of our own affairs; we may set up a passive resistance and cover retreat from post to post so long as may be possible; or, we may take advantage of the opportunity, if opportunity be permitted, to reconstruct our methods and devise a plan of our own which will give the people all they are justified in asking and at the same time save ourselves from the unjust and probably irremediable hardships which might be imposed by radical legislation.

During the past few months individual members of the profession, speaking in different parts of the country, have advocated each of those methods of procedure.

Our State Society can, in June, define a course of action and, if it speaks wisely, may influence the A. M. A. Convention in Milwaukee a week later. Our members have in hand all the facts necessary for a thorough study of the problem. Let us hope they will put aside all the nonsense recently spoken about "revolutionary recommendations" and "unfitness or prejudice of those who served on the Committee", and, dealing with essential facts alone, give the people and the profession a new deal.

Who and where is the leader we need?

Presessional Reports of Officers and Committees of the Medical Society of New Jersey

Annual Meeting—June 6, 7, 8, 9, 1933, Haddon Hall—Atlantic City

INTRODUCTORY NOTE

These reports have been prepared for publication in the Journal 1 month in advance of the Annual Meeting of the Society, in compliance with the official requirement established several years ago for the purpose of giving to Delegates advance information concerning matters with which they may have to deal in the House of Delegates. In some instances it is not possible to present a complete report so far in advance of the convention; the Society's fiscal year not ending until June first. Consequently, the "Annual Report"—actually presented and read to the Delegates—may differ in some respects from these advance, "Presessional" or "Preliminary" reports; they will in the main, however, harmonize even where they do not exactly correspond.

REPORT OF COMMITTEE ON SCIENTIFIC PROGRAM

The Committee on Scientific Program, together with the Officers of the State Society and the Chairmen of the several Sections, has arranged the program for the One Hundred and Sixty-seventh Annual Meeting of the Medical Society of New Jersey.

The Chairman wishes to take this opportunity to thank all those who have helped in the formation of that Program; and he would especially mention: Dr. Lippincott, President of the Society; Dr. Morrison, the Secretary; Dr. Reik, the Executive Secretary; and the Section Chairmen, Drs. Allen G. Ireland, Charles H. Schlichter, F. C. Johnson, and C. B. Kaighn. These men have worked together in harmony, and have coöperated with the General Chairman to the fullest extent.

The aim of the Committee has been to put on a good program, with as many papers as practicable presented by men of our own State, and with all sections of the State, geographically speaking, equably represented.

The hope of the Committee now is, that the program may be well received.

Submitted by the Committee on Scientific Work,

W. Blair Stewart, Chairman
Ralph K. Hollinshed
Louis C. Lange

PRESESSIONAL REPORT OF THE EDITOR AND EXECUTIVE SECRETARY

As stated in the introductory to this section of the Journal, *presessional reports* are published for the purpose, primarily, of informing Delegates to the Annual Meeting of the State Society what subjects will be presented for their official consideration and, more particularly, what expenditures of money and what new plans concerning organization work will be submitted for approval. Our regular Annual Report to the House of Delegates will this year consist mainly of a detailed account of the year's accomplishments. It will be shown that, despite many difficulties to be overcome and the steadily increasing amount of labor to be performed, every feature of the work entrusted to our care or guidance has been maintained on the same high plane of quality and up to the standards of excellence previously determined.

The Journal, we trust, has to a large extent spoken for itself; it has certainly supplied its readers, through the issues of January and April alone, with information of value far beyond its subscription cost for the entire year.

The educational and legislative work has been even greater than that of an average year, but the results have been as satisfactory.

The Field Secretary has, in character and quality of program for public education in medical matters, surpassed our highest hopes or expectations and the letters of approval and appreciation, voluntarily sent us by School Superintendents and other officials have not only increased in number but have reached the high limit of praise. Indeed, the requests for return engagements are now sufficient practically to fill her itinerary for next year.

Office work, which embraces all of that concerned with the Welfare Committee, and some of the Standing and Special Committees, as well as that of preparing and editing the Journal, has continued to increase, naturally, and has now passed the point of proper and complete handling by any 2 persons. There is no immodesty, we can assure you, in our saying that no other 2 persons than those now serving as Office Secretary and as Editor could do the amount and kind of work expected and required of this office; and we have been able to do it only by giving to it all of our time—including Sundays and Holidays. Compare the Journal, and our "out-put" in many other channels, with conditions in 1924, noting that we have not increased the number of laborers with which we started, and say whether or not we are entitled to another assistant. That will be the sum-total of our requests for the coming year. The need for an additional worker is not of recent origin. It has existed for 2 years, at least, but we have refrained from submitting it for consideration because of general business conditions. A number of things have happened during the past year, however, which will make it necessary to plan carefully for the future conduct of medical organization affairs and because some of those are at this moment being considered by the Officers of this Society we shall await their presentation at the Convention in June.

Respectfully submitted by

Henry O. Reik, M.D.

PRESESSIONAL REPORT OF THE FIELD SECRETARY FOR 1932-33

One outstanding development marks the close of the sixth year of the public education project of the Medical Society of New Jersey, namely, its definite acceptance by local school administrators as an annual contribution to their health programs in the schools. The proof of this statement lies in the fact that the yearly schedule of the Field Secretary is now practically automatically renewable. Almost without exception the parting words of the Principals are—"We shall expect you next year at the same hour on the same day of the week. Let us know the date."

It has taken 4 years of patient adjusting and readjusting, on the part of the County Superintendents of Schools, of all factors involved, to effect this degree of basic organization, and even at this stage it is not a rare occurrence to have a Principal say—"We are glad to see you. We have been trying for 2 or 3 years to get a place on your schedule."

There is a wide divergence among schools in the matter of the elasticity of assembly hours. Some principals will forego the talk rather than disturb the fixed order of classes; others will make any concession in shifting schedules rather than lose out on this yearly feature. To anyone who gives this matter any thought at all, it is readily apparent that, in the absence of secretarial help, a quite appreciable part of the Field Secretary's time goes into writing letters based upon consultation with map, calendar and files. Every appointment must first be offered, then confirmed. In cases of conflicting engagements several communications must often be exchanged before an adjustment is reached.

The new "talk" added to our repertory this year was on the subject of food—"You Are What You Eat"—and it has "gone over" exceptionally well. Its popularity was due in part to the intriguing title, which has received much favorable comment, and partly to the fact that, not only physiologically but also economically, it was most timely. The points stressed were desirable simplicity in diet, a cutting down in starches and sugar, increase in raw and properly-cooked vegetables and, above all, no risky self-experimentation with *yeast* or *bran* or any other *diet fads* except under guidance of the family physician. This talk has been given 136 times to date and was pronounced, in one High School, "the most important talk we have had in years". "The Common Cold" has been asked for 17 times; "Medical Quackery and Nostrums" 25 times; "Pasteur" 8 times; and "Mental Hygiene" 5 times.

At the writing of this preliminary report, with 2 counties still to be covered, the total number of talks for the year 1932-33 is thus brought to 191. The decrease shown in this figure in comparison with the total for the preceding year is more than accounted for by the elimination, at Dr. Ireland's suggestion, of the elementary schools. Several considerations made this step seem advisable: (1) Even the very rudimentary knowledge of chemistry which must enter into any discussion of diet is too advanced for pupils below the seventh grade. (2) The time thus gained would be available to more High and Junior-High Schools than could otherwise be included. (3) The speaker might feel, at the end of the year, more like a human being with some zest still left for her work, and less like a worn-out phonograph record, only faintly reminiscent of its early performances. It should be said here that the results of this revised policy seem to bear out the soundness of the original assumptions.

There has been a noticeable and easily explained decline this past winter and spring in the number of state organization and committee meetings. The only gathering of this sort addressed by your Field Secretary was a section of the New Jersey Conference of Social Workers. Medical Quackery, the subject requested by the Program Committee Chairman, seldom fails to arouse lively interest in audiences of all sorts and ages. At the Faculty luncheon of the Newark State Normal School it was followed by a discussion, on the part of the 40 men and women present, lasting one hour and a quarter, at the close of which your Secretary accepted the invitation of the Principal, Dr. Townsend, to return next year and spend 2 days at the school in class room conferences.

One of our most responsive audiences was found in the Civics Section of the New Century Club of Philadelphia. This invitation was extended through Mrs. A. Haines Lippincott, Program Committee Chairman of the Section, and its acceptance was endorsed by President Lippincott, in consideration of the large enrollment of New Jersey members. The occasion was productive of several requests for talks to other women's clubs in both New Jersey and Pennsylvania.

The State Normal School in Jersey City was again opened to us, for the fourth consecutive year, while the group of some 40 nurses, connected with the Board of Education there, welcomed us back for the fifth time.

Acceptance of an invitation to speak to the Alumnae Association of the Jersey City Hospital School of Nursing had to be postponed until next year.

A meeting with the 30 nurses of the Metropolitan Life Insurance Company for the Jersey City area formed a new contact which promises to be renewed annually.

The usual luncheon and meeting of the Hudson County Auxiliary to the Medical Society was greatly enjoyed by the speaker.

In Essex County the Health Officer of East Orange, Mr. F. J. Osborne, again gave us his wholehearted support. The following excerpt from the minutes of the meeting of the East Orange Health Department, March 2, 1933, will be of interest: "The Health Officer reported that Mrs. E. C. Taneyhill, who was in Essex County from February 6 to 16, under the auspices of the State Medical Society, gave a total of 23 talks, 12 of which were in East Orange, before combined audiences of 11,203, of which 4826, or 43%, were East Orange school children and others. The Board expressed appreciation of this further evidence of the State Medical Society's interest in our public health matters, and was pleased to learn that Mrs. Taneyhill had addressed *every public school in the city* while here. It was hoped that this service might be continued from year to year."

A luncheon of the Executive Board of the Essex County Auxiliary was followed by a meeting of about 60 members of the organization, where your Field Secretary contributed to the program dealing with mental prophylaxis. In the early Fall the talk on "The Common Cold" was given to an assemblage of 300 teachers and principals of Maplewood and South Orange. Adding to these groups the East Orange Kiwanis and the Verlitsa Club of Verona, we have a record of 27 talks in Essex County this year—an increase of 8 over the previous year and, taken in conjunction with the 2 days promised the State Normal School at Newark, justifying the assignment of 2 weeks for Essex County in 1934. Union County has for 3 years past required 10 days, and the rest of the counties are covered in 1 week each, or less. For economy's sake, Warren and Sussex Counties have been combined in an intensive 1 week program. We very much regretted the necessity of declining the invitation of one of the Helping Teachers to return to Sussex in April for participation in several health week programs. Lack of funds has made it impossible for us to revisit any of the distant counties this year.

The 191 talks to date have reached a total audience of approximately 71,200 individuals. Of these, 2100 were in adult groups, 3100 were school teachers and principals, and 66,000 were pupils in High and Junior-High Schools.

Respectfully submitted,

Ethel C. Taneyhill

PRESESSIONAL REPORT OF THE WELFARE COMMITTEE

In accordance with established custom, I am submitting a preliminary report of the work done thus far by your Welfare Committee for the year 1932-1933.

The newly appointed committee met at the Stacy-Trent Hotel on December 18, 1932, at the call of President Lippincott and proceeded to organize; Dr. Chas. H. Schlichter being unanimously elected Chairman.

A report upon State Society affairs covering the period of time since the Annual Meeting in June and up to December 1932, was submitted by the Executive Secretary, Dr. Henry O. Reik, who also directed our attention to certain matters carried over from last year.

Among the interesting features of his report, and one indicating the value of constant watchfulness, Dr. Reik told of his chancing to see, while traveling in Switzerland, in a Paris Edition of the New York Herald, an account of Governor Moore's appointment of the "Princeton Commission to study our existing methods of conducting the State's business and to recommend, if possible, a better plan"; of his having noticed that other professional and business representatives were being consulted but that medical affairs were, apparently, to be handled without any form of conference with physicians; of his having learned upon returning home that no one else had noticed this Commission nor had any knowledge of its work; and of his having, with the aid of Dr. Schauffler, opened negotiations with the Commission's Chairman and secured an invitation for our State Society to send a Committee to confer with the Commission on medical matters.

President Lippincott promptly appointed a Special Committee to follow up what the Executive Secretary and Dr. Schauffler had started and what proved to be an important relationship between the State Society and the Princeton Commission was established. A series of Conferences were held, in which we were represented by the Special Committee, consisting of Drs. Lippincott, McBride, and Green, assisted by Drs. Schauffler, Morrison, and Reik, and on some occasions by Drs. Mahaffey (and members of his Staff in the State Department of Health), Levy, McGuire, and English, called in because of their special knowledge regarding certain public health matters.

It was soon ascertained that matters affecting the medical profession had been given some attention but without much thought concerning the profession's interests. At conferences of our Committee with the Princeton Commission, the whole field of public health work was reviewed and many Committee suggestions were adopted by the Commission. Some of our recommendations have strengthened our position with regard to medical public relations; and we have supported all but 1 of the Commission's recommendations.

The important program of Post-War Legislation is being looked after by a sub-committee under the chairmanship of Dr. McBride, which is studying the medical care and hospitalization of alleged Veterans of the World War. The recent action of Congress, however, giving President Roosevelt unlimited power in this matter, will probably change the picture. More of the details concerning this may be given in our final report to be submitted to the House of Delegates at the June meeting.

The Majority and Minority Reports from the National Committee on the Costs of Medical Care are in the hands of a Special Sub-Committee for consideration and that Committee's Report will be made at the Annual Meeting of the State Society to be held in June.

It was deemed inadvisable to introduce this year an amendment to the Hospital Lien Law, but some one, as yet unknown to us, has introduced a Bill dealing with physicians separately in this matter, and its course is being watched.

Among the many Bills introduced this year is one (S-229) dealing with the narcotic situation. After a number of conferences, the Uniform Narcotic Bill, designed to meet the requests of the United States Government and the American Medical Association, was drawn and is now before the Legislature. The usual Osteopathic and Naturopathic Bills are also before the Legislature and being watched by your Committee. A hearing was held on Senate Bills 125 and 126 at which we were represented by counsel, the Officers of the State Society and a number of members of the Welfare Committee attended. These bills were designed to take away the "allocated funds" of the State Board of Medical Examiners. The Executive Secretary and a Special Sub-Committee consisting of Drs. D. Leo Haggerty, Chairman; Harry R. North and George N. J. Sommer with Dr. James McGuire, Secretary of the State Board of Medical Examiners, all have been and will continue watching legislation. These men and the Executive Secretary, Dr. Henry O. Reik, have analyzed and studied all bills carefully, and have done splendid work in keeping the Welfare Committee advised as to the progress of legislation of even remote interest to the State Society. The plan that members of the Welfare Committee should individually maintain contact with legislative representatives of their own county, Assemblymen and Senators, has been again followed this year and seems to continue working effectively.

Contact has been made by each member of this State Society Committee, either personally or through the various County Welfare Committees or County Public Health Relations Committees, with each State Senator and State Assemblyman. In this way we have been able to keep up and in constant touch with pending legislation.

Dr. J. Lynn Mahaffey, State Director of Public Health, and Dr. James McGuire, Secretary of the State Board of Medical Examiners, have been present with this Committee at every meeting. Dr. Fischelis, Secretary of the State Board of Pharmacy, has been present at a number of meetings and his advice and suggestions regarding legislation have often been very helpful to the Committee.

The attendance of members of this committee has been exceptionally good. Even in the most inclement weather men have come long distances to be present and perform their duties, and there were but very few absentees from any of this Winter's sessions of the Welfare Committee. Too much cannot be said of the self-sacrificing work that these loyal members of the State Society are doing.

The services of the Executive Secretary have been of the greatest value to the Committee. Aside from the things previously mentioned, he has kept the Committee informed regarding all Bills, and his insight and forethought in legislative matters, and his experience in handling such a variety of problems have been of real value. He has established personal relations with many members of the legislature, and when it was deemed necessary advised with them personally concerning urgent matters. The Chairman of your Welfare Committee is under a great personal obligation to Dr. Reik for his splendid, willing and hearty coöperation in all matters pertaining to the work of the Committee.

Chas. H. Schlichter, M.D.,
Chairman

REPORT OF SPECIAL COMMITTEE ON MATERNAL WELFARE

Arthur W. Bingham, M.D., Chairman

Considerable interest has been shown in the counties for organizing Maternal Welfare Commissions, and the work is progressing as well as could be expected. All of the counties except Warren are now represented in this maternal welfare work and in time we hope to report improvement in statistics in maternity care in this State.

There were 2 meetings of the State Committee with the County Commissions last year. The first was held in Atlantic City on June 15 and, while not very largely attended, it proved to be of great interest to the members present. The second meeting was held in Newark, December 1, 1932, and was attended by 30 men representing 10 counties: Bergen, Burlington, Camden, Cape May, Essex, Hudson, Monmouth, Passaic, Salem, and Somerset. After hearing reports from the County representatives, dinner was served by the Essex County Maternal Welfare Commission for the out-of-town guests, and then Dr. H. J. Stander, of the Cornell Medical Center, gave a talk on "Nephritis Complicating Pregnancy", which was enjoyed by all.

The next meeting will be held at Atlantic City on Friday afternoon, June 9, 1933, when Dr. Philip F. Williams, of Philadelphia, will give a talk on "The Avoidable Factors in Maternal Mortality", and reports from the County Maternal Welfare Commissions will follow. A full attendance is urged.

On looking over the New Jersey State statistics for the past 10 years, we find that ¾ of the maternal deaths were due to preventable causes. Sepsis stands first among the causes of death each year. Toxemia is next with ½ as many. Accidents of labor and hemorrhage follow closely. Sudden deaths and accidents of pregnancy come last. There are also altogether too many still-births. When the results of the past 5 years are compared with the preceding 5 years, we find that in 10 counties statistics have been slightly improved and in 11 counties they have become slightly worse. There is no doubt but that these statistics can be improved and right here is a great field for constructive work.

The Committee recommends no fads nor complicated methods of procedure but it does emphasize 4 points.

(1) Better pre-natal care; meaning pre-natal care for more patients, and more comprehensive care for each patient; pre-natal care which anticipates complications by preventive treatment before symptoms appear. It is not sufficient to practice *watchful waiting* and the treatment complications as they arise. Here is a line of work which can be improved in every County.

(2) Better technic in the care of even a normal condition. With a little more thought, and more attention to details, better results will be obtained.

(3) Better obstetric judgment, by which patients are steered along a normal course and fewer radical operations attempted. We recommend trying to keep the normal patient normal, with operative procedures reduced to the minimum.

(4) Early consultation in the face of complications. Much improvement will be made in final results if this idea is adopted, and every hospital should have rules requiring consultation under certain conditions. This feature is imperative and is urgently recommended.

Maternal Welfare Committee: Theodore Teimer, George Van Voris Warner, P. DuBois Bunting, John F. Condon, Carl Ill, Walter B. Mount, and A. W. Bingham, Chairman.

PRESESSIONAL REPORT OF THE COMMITTEE ON HOSPITALS AND MEDICAL EDUCATION

The work of this Committee has consisted this year of 2 principal parts:

I. The Society at its 166th Annual Session, in Atlantic City, in June 1932, directed the Committee to:

(1) Formulate "hospital standards" for licensure by the State Department of Institutions and Agencies, to be recommended to the Medical Society of New Jersey for adoption, and to be transmitted to the Commissioner of Institutions and Agencies of New Jersey, requesting that he apply them *as standards* to the work of his Department in licensing any and all hospitals in the State.

(2) Formulate "definitions and standards" to be recommended to the Medical Society of New Jersey, as a basis for the determination of the relationship of its members to hospitals, clinics and dispensaries.

II. Operation of the Courses in Post-Graduate Medical Education in collaboration with Rutgers University pursuant to the program inaugurated several years ago.

The Committee met in Trenton September 25, 1932, at which time a sub-committee was appointed to lay the groundwork for the first part of the Committee's program outlined, and a report of progress was received relative to the post-graduate courses.

In December, 1932, a tentative report of this sub-committee was submitted to the Board of Trustees, and was referred back to the sub-committee for reconsideration of some details.

On April 9, 1933, the sub-committee re-submitted its report, with changes based on recommendations from the American Hospital Association, the American Medical Association, and other sources, and its report was accepted by the full Committee. On the same date, this report was transmitted to the Board of Trustees by the Chairman, but the latter body preferred not to act on it without adequate study, and directed that copies there-of be struck off and mailed to all Officers of the Society, members of the Board of Trustes, and all members of the Committee; the action of the Board of Trustees there-on to be deferred until their own Board's meeting immediately before the June session of the Society. A copy of the amended report is attached hereto.

At the same meeting of the Committee a further progress report of the Post-Graduate Medical Education program was received, and accepted, as follows:

Prof. Miller reported that courses had been or were being given to 19 groups, well distributed throughout the State, with a total enrollment of 425. Because of the low-fee charged, and the large number of groups organized, the income from operation of these courses had sufficed only to cover the fees paid to lecturers, traveling expenses of the lecturers, traveling expenses of the University representatives, and certain incidental expenses; so that the University Extension Division of Rutgers University had been compelled to carry practically the entire organization overhead, and the salaries of their own employees whose time had been wholly or largely devoted to this work. This, the University Extension Division had been able to do only by curtailing certain other phases of adult education. The action taken was based on the opinion of the University authorities, that the work in Post-Graduate Medical Education transcended in importance that of certain other lines of adult education.

Prof. Miller emphasized the necessity of operating the whole State, as a unit, in the setting-up and operation of these courses, and said that to meet the present financial distress of the profession generally, he had already tacitly committed the University to a fee of $10 for the ensuing year 1933-34. He said the quality of service had been unusually high this year, by reason of accumulated experience permitting a more discriminating selection of lecturers.

Dr. Satchwell reported for consideration of the Committee, that he feels, for future courses, the State Society Committee should have the final decision as to the particular courses selected by local groups, in as much as this will permit the State Society Committee to make available to individual members a greater variety of opportunity, by offering different courses in geographically adjacent localities.

He also advised strong effort to introduce a larger factor of instruction from clinical material in courses offered.

He further discussed the effect on operation of the State Society Committee's program, of independent action (in setting up courses of their own) by the more populous counties; pointing out that the State Society, without direct subsidy from its own treasury, would be unable to offer these courses in the rural sections of the State, if this general program is not supported in the more populous counties. In other words, the more populous counties owe a large degree of direct support to the State Society, thus helping to make this State-wide program possible.

Drs. Pyle, Quigley and Cosgrove discussed this phase of the matter from the standpoint of the populous counties, the consensus of opinion being that while it was true that the more populous counties had been able, in prosperous years, to conduct excellent courses under their own auspices, at a saving of money to subscribers, and at times even adding a profit to their own treasuries, their experience in less prosperous times had not been so fortunate, and some of the courses so operated during the current year had resulted in a financial deficit; that undoubtedly the populous counties did owe allegiance and support to the State Society, in operating a State-wide program, but it is unfair to tax these populous counties without limit, for the support of the State program; that in order to prevent over-taxation of the populous counties, it would be wise to fix a maximum cost for courses which instruction groups in the populous counties would be expected to meet, in order to contribute to the cost of courses in the less populous counties.

It was there-upon regularly moved, seconded and carried, that Prof. Miller be requested to ask the approval of his Board of Regents of a plan of financing, whereby the income from large instruction groups in the populous counties would be available to subsidize work for smaller instruction groups in less populous counties, but that income so derived should not exceed certain fixed maximums, any income above said fixed maximums being used to diminish the cost of instruction to the members subscribing to the large groups.

On Prof. Miller's request, the Committee instructed the Chairman to check up again with the County Medical Societies, as to their compliance with the Committee's request to give their local committee on post-graduate medical education a permanent status.

The Chairman then called attention to the very valuable and self-sacrificing work which Dr. Satchwell had done on behalf of the Committee and in collaboration with Rutgers University, in setting up the instruction outlines for this year's courses; in selecting and contacting lecturers and in many other valuable ways, in acting as technical adviser to the University Extension Division. Therefore, upon motion regularly made, seconded and carried, the Committee unanimously extended an expression of appreciation to Dr. Satchwell for his splendid work and ordered that this action be spread upon the minutes.

Respectfully submitted,

S. A. Cosgrove,
Chairman

At the 166th Annual Session of the Medical Society of New Jersey at Haddon Hall, Atlantic City, N. J., in June, 1932, the following specific duties were imposed on the Committee on Hospitals and Medical Education of the Medical Society of New Jersey:

(1) "The formulation of hospital standards for licensure by the State Department of Institutions and Agencies, to be recommended to the Medical Society of New Jersey for adoption, and to be transmitted to the Commissioner of Institutions and Agencies of New Jersey, requesting that he apply them *as standards* for the work of his Department in licensing all hospitals in the State."

(2) "The formulation of definitions and standards to be recommended to the Medical Society of New Jersey, as a basis for determination of the relationship of its members to hospitals, clinics and dispensaries."

This Committee in turn referred them to a sub-committee. This sub-committee hereby submits the enclosed report, together with the recommendation that the Committee on Hospitals and Medical Education of the Medical Society of New Jersey study and revise the rules and regulations, and submit them for further study to the American Medical Association, the American College of Surgeons, the American Hospital Association, the Attorney-General of the State of New Jersey, the Department of Institutions and Agencies of the State of New Jersey, and the New Jersey Dental Society, before presenting them for approval by the Medical Society of the State of New Jersey.

J. H. Carlisle
Vincent Smith
Charles B. Kelley
Wm. J. Carrington,
Chairman

(The following pages exhibit an *amended report* submitted by the sub-committee, and adopted by the whole Committee, at a meeting in Trenton, Sunday, April 9, 1933. Under "Special Regulations", the second sentence, par. 1, was added subsequently, at the suggestion of members of the Board of Trustees. Par. 3 has been changed in verbiage for clarification. S. A. Cosgrove, Chairman.)

The formulation of hospital standards for licensure by the State Department of Institutions and Agencies, to be recommended to the Medical Society of New Jersey, for adoption, and to be by that Society transmitted to the Commissioner of Institutions and Agencies of New Jersey, requesting that he apply them as standards for the work of his department in licensing all hospitals and dispensaries in the State.

(1) *Hospitals in New Jersey fall into 5 groups, Federal, State, County, City, Town and Village Hospitals.* These shall be subject to "Rules Applicable to All Hospitals and Dispensaries" (A) which are appended to this report.

(2) *Incorporated Profit, Non-profit and Charitable Hospitals.* Many such hospitals receive pub-

lic funds, either on a per capita basis for the care of patients, or annual appropriations. These Institutions shall be subject to "Rules Applicable to All Hospitals and Dispensaries" (A), and to "Special Regulations for Hospitals" (B).

(3) *Proprietary Hospitals.* These are business enterprises conducted by individuals and partnerships. These shall be subject to "Rules Applicable to All Hospitals and Dispensaries" (A).

(4) *Unincorporated Maternity Homes and Hospitals.* These are institutions where women, not related by blood or marriage to the proprietor, are received to be cared for during pregnancy, parturition and puerperium. Such institutions shall be subject to "Rules Applicable to All Hospitals" (A) and "Special Regulations for Maternity Homes and Hospitals" (C).

(5) *Dispensaries.* A dispensary is an institution, corporation, association or agency, the purpose of which is to furnish medical, surgical or dental advice or care to persons not resident therein. Dispensaries shall be subject to "Rules Applicable to All Hospitals" (A), and "Regulations for Dispensaries" (D).

A

Rules Applicable to All Hospitals and Dispensaries in the State of New Jersey

(1) *License.* Each hospital and dispensary in New Jersey shall be licensed annually by the State Department of Institutions and Agencies as is provided by law. Each institution shall file with the State Department of Institutions and Agencies upon application for licensure, and at such times as the Department may subsequently require, certificates from the local Board of Health and the State Board of Health as to their sanitary conditions, and from the Department of Safety of the city, town, village or borough in which the institution is located as to its structural safety. No hospital or dispensary shall enter upon the execution, or continue the prosecution, of its purpose without a license issued by the Department of Institutions and Agencies of the State of New Jersey, as is provided by law. This license shall be posted in a conspicuous place.

(2) *Change of Location or Ownership.* Upon intended change of location, ownership, or management, the Department of Institutions and Agencies shall be notified. Before a change of location, ownership or management the Department of Institutions and Agencies shall issue a new license.

(3) *Name.* Each hospital or dispensary shall have a name which shall appear on the license and on all certificates of birth or death occurring there-in.

(4) *Capacity.* Each license shall be for a maximum number of patients. Admissions beyond this number are prohibited except in emergency.

(5) *Admission.* All persons applying for *free* treatment, wholly or in part, shall be refused admission except: (a) The patient or guardian sign a statement of his or her inability to pay a regular physician, surgeon or dentist. This statement shall appear on a pass card on which also shall be printed the penalty for false representation in the State of New Jersey (Statute, May 2, 1932, appended to this report). (b) All "emergency cases" shall be admitted, regardless of the patient's ability to pay, and the patient shall receive prompt treatment and care until the emergency is controlled, but no longer, on a free basis, if the patient is not a proper subject for continued free care.

(6) *Records.* (a) A record shall be kept for each admission, including identification data, complaint, history, physical examination, x-ray and clinical laboratory findings, reports of special examinations, surgical findings, description of operation, description of autopsy, treatment, progress notes, final diagnosis and condition on discharge. (b) A record shall be kept of admission, revisits, applications refused. (c) A record of receipts and expenditures shall be kept. (d) A register shall be kept to show the attendance of physicians, surgeons and dentists.

(7) *Sanitary Conditions.* Each institution shall be kept in a sanitary condition in accordance with local and state laws. These include potable water, proper drainage, adequate sewerage and suitable bath and toilet facilities. All outside openings shall be screened from April 1 to November 1. No hospital, nursing home, home for convalescents, or for aged or chronic patients, or maternity home or hospital shall be housed in a multiple dwelling.

(8) *Ventilation and Beds.* Bed patients shall each have a separate bed in a room with at least one outside window. The beds shall be separated at least 3 feet in each direction. There shall be at least 100 square feet of floor space, and at least 800 cubic feet of air space for each adult, and at least 250 cubic feet of air space for each infant. In all institutions there shall be adequate ventilation. All beds here-after purchased or replaced, shall be of metal.

(9) *Room for Isolation.* In all institutions caring for in-patients at least one room shall be provided for the isolation of contagious or infectious diseases.

(10) *Hot and Cold Water.* Each institution shall have ample facilities for furnishing hot and cold water sufficient for sanitary and professional requirements.

(11) *Heat.* The institution shall be equipped with heating appliances sufficient to maintain a healthful temperature in the coldest weather.

(12) *Light.* Artificial lighting shall be by electricity unless special written permission be granted by the Department of Institutions and Agencies. All electric installation and equipment must be approved by the local authorities.

(13) *Linen, Etc.* Individual towels, wash cloths, clothing and toilet articles shall be provided. All bed linen and bed clothing shall be changed when soiled or wet, and shall be cleaned by modern laundry methods, or boiled and washed and dried in the open air, or in a room provided for that purpose. All bed linen shall be changed at least twice a week.

(14) *Walls, Floors, Ceilings and Furniture.* All walls, floors, ceilings and furniture in rooms occupied by patients shall be washable.

(15) *Fire Protection.* Each floor shall be equipped with approved fire extinguishers. No patient shall be cared for above the second floor except in fireproof buildings, or in buildings equipped with a sprinkling system, and unless the upper floors be provided with fireproof stairways at least 3 feet in width, and at an angle of not more than 45°, or fireproof ladders, steps, ramps or slides.

(16) *Separation of Children from Adults.* There shall be complete and continuous separation of children between the ages of 2 and 16 years from adults in all wards of all institutions.

(17) *Mortuary.* A separate room to be known as a mortuary shall be provided in all hospitals of more than 5 beds. A permit must be secured from the Board of Health for the removal of a dead body from the hospital.

(18) *Miscarriage or Abortion.* All cases of miscarriage or abortion and all applications for disposal of fetus, or for cremation, shall be referred immediately by telephone to the local Department of Health.

(19) *Criminal Practice.* All cases of suspected

or discovered criminal practice shall be referred immediately to the prosecuting attorney of the County in which the institution is located.

(20) *Drugs, Medicines and Solutions.* All drugs, medicines and solutions shall be properly labelled and shall be kept under lock and key accessible only to the physician or nurse in charge.

(21) *Pharmacy.* If a pharmacy is maintained in connection with the institution, it should comply with the laws of the United States and of the State of New Jersey.

(22) *Physicians, Surgeons and Dentists.* Only physicians, surgeons or dentists shall be permitted to diagnose or care for patients. (a) Who are legally licensed to practice in New Jersey by the State Board of Medical Examiners. This regulation shall not apply to consultants who are licensed and in good standing in other states or countries, or to graduates of accredited medical colleges who are serving as resident physicians or interns. (b) Who are eligible for membership in a Component Society of the Medical Society of New Jersey. (c) Who are pledged to abstain from fee-splitting under any guise.

(23) *The Administrative Officer.* The Administrative Officer shall be selected by the governing body, and under its direction shall have charge of, and be responsible for, the administration of the institution in all its branches and departments other than those concerned with the medical care and treatment of patients.

The Administrative Officer shall assign the duties to be performed by Resident Physicians and Interns. These regulations shall not apply to Administrative Officers who are licensed physicians, and who are assigned medical duties by the governing body.

The Administrative Officer shall have charge of the admission and discharge of all patients or inmates, and shall have the right to call upon the visiting staff, or a member of it, to certify to the necessity or the advisability of admitting or discharging a patient or patients.

No person shall be denied admission as a patient for any reason, racial, religious or moral, if he or she is within the type or class of patients prescribed for admission to the hospital; provided, however, that space and facilities are available for the care and treatment of the patient.

The Administrative Officer shall assign beds for patients. He shall determine, in the first instance, for the governing body the ability of patients to pay for all or part of their care or treatment, or he may delegate this in writing to a competent assistant.

(24) *Resident Physicians and Interns.* Resident Physicians and Interns shall meet the requirements of the Board of Medical Examiners of the State of New Jersey as provided by law.

(25) *Nursing Service.* The hospital shall supply adequate nursing services under the direction of a registered, graduate nurse.

(26) *X-rays.* The X-ray Department shall be under the direction of a licensed physician holding the degree of Doctor of Medicine and recognized as a Roentgenologist. All x-ray films shall be filed in the institution under the conditions and regulations prescribed by the local Fire Department.

(27) *Inspection.* Inspection of the physical plant, equipment and case records by the Department of Institutions and Agencies, the Medical Society of New Jersey, the State Board of Health, or the local Board of Health, or their representative shall be permitted at any time.

(28) *Revocation of License.* The Department of Institutions and Agencies, in the interest of the public good, for just and reasonable cause, may revoke the license of any unincorporated institution that fails to comply with all local, state or national laws, ordinances, rules or regulations, after notification and a hearing. The revocation order shall be signed by the officer of the Department of Institutions and Agencies, and shall state the reason therefor.

The Department of Institutions and Agencies shall apply directly to the courts to revoke the license and annul the incorporation of any incorporated institution that fails to comply with all local, state or national laws, ordinances, rules or regulations.

B

Special Regulation for Incorporated, Profit, Non-profit and Charitable Hospitals in the State of New Jersey

(1) Physicians, surgeons and dentists permitted to practice in the hospital, shall be organized as a Staff. All appointees to the Staff shall be approved by the Staff as to professional qualifications and medical ethical standing, as a requisite to appointment.

(2) Membership on the Staff shall be limited to physicians, surgeons and dentists: (a) Who are graduates of professional schools recognized by the Board of Medical Examiners of the State of New Jersey, and who are legally licensed to practice in the State of New Jersey. (b) Who are competent in their respective fields. (c) Who are of high character and ethical. The division of fees, under any guise what-so-ever is unethical. (d) Who are eligible for membership in a Component Society of the Medical Society of New Jersey.

(3) The Staff shall initiate and recommend to the Governing Board of the hospital, for adoption, rules, regulations, and policies governing the professional work of the hospital; or/and shall approve before adoption such rules, etc., initiated by the governing board; or/and, with the approval of the Governing Board, may itself adopt such rules, regulations and policies.

(4) Staff meetings shall be held at least once a month during at least 8 months of the year.

(5) The Staff shall review and analyze their clinical experiences in the various departments of the hospital, including the discussion of deaths and autopsy findings, if any.

(6) Accurate and complete written records of all patients shall be filed in accessible manner in the hospital.

A complete case record includes the following: (a) Identification data. (b) Complaint. (c) Personal history. (d) Family history. (e) History of present illness. (f) Physical examination. (g) Special examinations: (1) Consultations; (2) clinical laboratory findings; (3) x-ray. (h) Working diagnosis. (i) Medical, surgical or dental treatment. (j) Gross and microscopic findings. (k) Progress notes. (l) Final diagnosis. (m) Condition on discharge (in case of death autopsy findings). (n) Follow-up.

(7) A clinical laboratory shall operate only under the direction of a graduate of an accepted medical or scientific college who has had adequate training in clinical pathology. Smaller hospitals shall either meet this requirement, or supply this laboratory service from outside sources, that meet this requirement.

(8) X-ray facilities shall be available and shall be under competent medical supervision either within the hospital or available from outside sources.

(9) The Staff shall be divided into specialties and assigned to departments commensurate with the degree of specialization in the community.

(10) In "open" hospitals, ethical, competent, licensed physicians, surgeons and dentists may be allowed full use of the pay wards and private rooms for their patients, provided they meet the requirements of the Governing Body of the institution.

C

SPECIAL REGULATIONS FOR UNINCORPORATED MATERNITY HOSPITALS AND HOMES IN THE STATE OF NEW JERSEY

(1) *Obstetric Attendance.* Every patient shall be attended during confinement, and supervised during the puerperium by a graduate physician, or licensed midwife.

(2) *System of Identification.* One of the following systems of identification shall be provided and shall not be removed from mother or child until discharged: (a) Finger print of mother and foot print of baby shall be recorded before leaving the delivery room. (b) Adhesive tape, or linen tape, on mother's wrist and baby's wrist shall be applied before leaving the delivery room. Each shall bear the admission date, date of birth and full name of mother. (c) A necklace of lettered beads shall be placed around the infant's neck before leaving the delivery room. The beads shall form the admission number of the mother and the baby's surname.

(3) *Employees.* No person shall be employed in any Maternity Hospital who is known to be a carrier of, or a sufferer from a communicable disease. Each employee shall have a complete physical examination at least annually.

(4) *Communicable Diseases.* No Maternity Hospital shall accept a patient having any communicable disease. Should such a disease develop after admission the patient shall be isolated in accordance with instructions of the local health officer, and the bedding and equipment shall not be used again until disinfected, and no other patient shall be admitted without the knowledge or consent of the Health Department.

(5) *Separate Rooms for Maternity Patients.* No maternity patient shall be cared for in the same room with a non-maternity patient.

(6) *Breast Feeding.* Artificial feeding shall not be resorted to except upon order of a physician.

(7) *Separate Equipment.* Equipment used for maternity cases shall not be used for other patients.

(8) *Separate Delivery Room.* A separate delivery room shall be provided with adequate equipment, and maintained as such, and only as such at all times.

(9) *Minimum Equipment.* Each Maternity Hospital, or Maternity Home shall have the following minimum equipment:

General. Two clinical thermometers—mouth and rectal; sterile hand brushes; nail cleaners; liquid soap; Lysol or bichloride tablets; sterile caps and gowns; adequate supply of sterile dressings; 2 basins; 2 pitchers, for hot and cold water; covered metal waste container; provision for sterilizing instruments and water, and for steam sterilization of supplies.

Beds and Bedding. A single bed for each patient; suitable springs and mattresses; rubber sheeting; washable bedding; adequate supply of clean linen; block for beds (8 to 10 in. high).

For Mother. Breast tray; wash basin; small pitcher; bed pan or douche pan.

For Baby. Basket, bassinet or crib; baby's tray; sets of baby clothes; ampoules of silver nitrate; sterile cord dressings; blunt scissors; baby basin; covered pail for soiled diapers.

D

REGULATIONS FOR DISPENSARIES AND CLINICS IN THE STATE OF NEW JERSEY

(1) There shall be posted in a conspicuous place in the waiting room for applicants the following: (a) The license issued by the Department of Institutions and Agencies of the State of New Jersey. This shall be kept properly framed under glass. (b) A copy of the New Jersey Law of May 2, 1932, with penalty for false representation, as appended to this report. This shall also be kept properly framed under glass.

(2) *A Pass Card* shall be issued to each applicant admitted for treatment. On one side of the card shall appear the patient's admission number, together with the hours the clinic is held. On the other side of the card shall appear a copy of the false registration law of the State of New Jersey, the penalty for its infraction, and a statement that the patient is financially unable to secure the services of a licensed physician, surgeon or dentist. This statement must be signed by the patient or the guardian of the patient.

(3) *Gynecologic and Obstetric Procedures.* No examination or treatment or operation shall be performed on a female patient except in the presence of another woman detailed for such duty.

(4) *Pharmacy.* If a pharmacy is maintained in connection with the clinic it shall comply with the Laws of the United States and of the State of New Jersey.

(5) *Waiting Rooms.* A waiting room shall be provided with sufficient seating capacity, proper ventilation and suitable hygienic arrangements.

(6) *Treatment Rooms.* Treatment room or rooms shall be equipped with adequate appliances and supplies.

(7) *Drug Store Not to Be Used by Dispensary.* No dispensary or clinic shall make use of a drug store.

(8) *Unlawful Display of Signs.* No person, corporation, institution, society, association or agent thereof, except a duly licensed dispensary, shall display or cause to be displayed a sign or other thing on which shall be written or printed the words or characters which could directly or indirectly by suggestion indicate the existence of the equivalent in purpose and effect of a dispensary.

"The formation of definitions and standards to be recommended to the Medical Society of New Jersey as a basis for the determination of the relationship of its members to hospitals, clinics and dispensaries."

Members of the Medical Society of New Jersey are encouraged and urged to continue to serve the poor, the needy and the necessitous in hospitals, maternity homes, clinics and dispensaries, and to render those who cannot select their professional advisers their highest diagnostic and therapeutic skill, provided:

(1) The institution shall be licensed by the Department of Institutions and Agencies of the State of New Jersey.

(2) False representation and hospital and dispensary abuses shall be promptly punished.

(3) Fee-splitting shall be prohibited.

(4) Coöperation shall be established and maintained between the governing body and the Medical Staff. It shall be the duty of the Staff to recommend scientific, professional and medico-administrative policies to the governing body. One of the following methods of promoting coöperation shall be adopted, unless otherwise provided by law. (In certain county, state and federal institutions the governing body is by law composed of lay and professional members.)

(a) A joint conference committee consisting of representatives of both bodies shall meet regularly to discuss matters of mutual interest.

(b) A medical council or medical board shall take up clinical administrative problems with the governing body. This council or board shall consist of the Chief of Staff and several senior members of the Staff, together with the Superintendent of the hospital, ex-officio.

(c) The Staff shall be represented on the governing body by voice and vote of a committee or at least one member of the Staff—the President of the Staff, the Chief of Staff, or a retired member of the Staff whose professional training and long years of experience equip him for such service.

The addition of a retired member of the Staff to the governing body avoids the appearance of unfair competition.

Be it enacted by the Senate and General Assembly of the State of New Jersey.

(1) Any person who, by false representations with respect to the ability of such person to pay the usual and reasonable cost of medical and/or surgical treatment for such person, or another, shall secure such medical and/or surgical treatment from any state, county, municipal or charitable hospital or institution, free or at reduced rates, or who shall by false representations as to his or her financial situation obtain from any department of public welfare or overseer of the poor of any county or municipality, financial or other assistance in any form, shall be guilty of a misdemeanor.

(2) This Act shall take effect immediately.

Approved May 2, 1932.

PRELIMINARY REPORT OF THE COMMITTEE ON LIFE, HEALTH AND ACCIDENT, AND AUTOMOBILE INSURANCE

Our regular annual report will be made at the convention. This is to announce briefly the latest developments concerning our Health and Accident policy. The Independence Indemnity Company insuring us was absorbed last October by the International Re-Insurance Corporation, and the latter went into receivership April 19, 1933. The cause seems to be in the financial conditions which have involved so many banking and other financial institutions throughout the country. Our unique policy is acknowledged, even by competitors, to be a rare advantage to the members of our Society, but, in addition, we know from records of this policy with the company that it is also profitable enough for them to carry it. On receipt of the news of the receivership, we at once directed that the agent must not receive any more checks from our members for premiums. We also at once opened negotiations for a trustworthy company to continue our policy unchanged and, if it could possibly be done, save the unearned premiums paid. Besides these 2 desirable considerations the reliability of any company in assets, liabilities, safety, history and moral character was of supreme importance. The best proposition was negotiated with the National Casualty Company of Detroit, through our agent's (Mr. Blanksteen) energy and knowledge of insurance. Its record with the New Jersey Commissioner of Banking and Insurance, and confidential reports to us by the Alfred M. Best Company, publishers of Best's Casualty Insurance Reports, substantiate the trustworthy character of the company in the above respects and we are fortunate in offering to you our policy, not changed in any word, and at the same low premium rates to all members of the Society, in 3 groups, by ages. Existing policy-holders were notified April 28, 1933, that they were *covered* as before on that day at noon.

Respectfully submitted,

Frank W. Pinneo, Chairman
J. Finley Bell
Austin H. Coleman
James S. Green
Frederic J. Quigley
Chester I. Ulmer
Clarence W. Way

PRESESSIONAL REPORT OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS

To the House of Delegates:

The Committee on Constitution and By-Laws offers for adoption the following amendments to the Constitution, to be accomplished in conformity with Article XII. These amendments were submitted in writing and read at the last Annual Meeting (1932).

(1) Article IV. Section 1. (p. 6.) Strike out the entire wording and substitute: "This Society shall be composed of Fellows, Officers, Delegates, and Members of Component Societies in good standing."

(Explanation: This amendment was suggested and worded by Mr. Wall, Counsel to the State Society, in conformity with the Charter of the Society.)

(2) Article IV. Section 2(b). (p. 6.) After the comma following the word "President" delete the words "three Vice-Presidents" and substitute the words "a President-Elect and two (2) Vice-Presidents".

(3) Article IV. Section 3, paragraph c. (p. 7.) Strike out the entire subsection.

(Explanation: Certificates signed by officers of component societies accrediting Delegates unnecessary, as each Delegate is accredited by certificate issued by the Secretary of the Medical Society of New Jersey.)

(4) Article IV. Section 3(d). (p. 8.) Strike out the word "a" in the second line.

(Explanation: As amended, the beginning of this sub-section will read—"In the event that a Component Society becomes delinquent to this Society . . .")

(5) Article IV. Section 3(d) and (e). (p. 8.) Change to subsections (c) and (d) respectively.

(Explanation: Relettering subsections made necessary by deletion of subsection [c].)

(6) Article IV. Section 3(f). (p. 8.) Strike out the word "his" (last line on p. 8, last word) and substitute the word "an".

(Explanation: The purpose of this proposal is to permit any Alternate to take the place of any Delegate unable to attend, rather than requiring a particular Alternate for each Delegate.)

(7) Article IV. Section 4. (p. 9.) Strike out entire wording and substitute: "All members of Component Societies in good standing are hereby constituted members of this Society, and entitled to participate in all the privileges of general and scientific sessions."

(Explanation: Suggested and phrased by Counsel to State Society.)

(8) Article VI. (p. 10, first line.) Strike out the words three (3)", and substitute "President-Elect and two (2)".

(Explanation: This amendment as well as proposed amendment to Article IV Section 2(b) is in

conformity with the tendency of most medical organizations to have a "President-Elect".)

(9) Article VIII. Section 2. (p. 10.) After the word "Delegates" (first line of section) and before the word "may", insert the words "or the Board of Trustees".

(Explanation: If circumstances make it advisable, between meetings of the Society, to create a new section for scientific work, the Board of Trustees is authorized to create such section or sections.)

(10) Article IX. Section 2. (p. 11.) Strike out the numeral "3" (fifth line of section) and substitute "President-Elect and two (2)."

(11) Article IX. Section 2. (p. 11.) At the end of the first sentence, replace the period with a comma, and add the following: "except that the President-Elect shall succeed to the office of President without process of nomination and election."

SUGGESTED AMENDMENTS TO THE BY-LAWS

After extended debate at the last Annual Meeting (see pp. 7-12 Official Transactions 1932) the question of a more suitable time for the meeting of the Nominating Committee was referred back to this committee, for report at the next Annual Meeting.

This committee is of the opinion, that the evening of the first day of the meeting would be a more suitable time for the Nominating Committee to meet; and so as to accomplish this, we offer the following:

Amend Chapter V, Section 1, by deleting, in the first and second lines of the last paragraph, following the word "at" and before the word "the", the words "the close of the afternoon sesion on", and substitute "8:30 p. m."

(Explanation: The Nominating Committee would then meet at 8:30 p. m. the first day of the Annual Meeting, instead of at the close of the afternoon session.)

This committee recommends that the following special committees be made Standing Committees: (1) Committee on Medical Defense, (2) Committee on Health, Life and Automobile Insurance (to be renamed Committee on Insurance).

Amend Chapter VIII, Section 2, by adding immediately under the words "Hospitals and Medical Education" the words "Committee on Medical Defense" and immediately under these words "Committee on Insurance".

Amend Chapter VIII by renumbering Sections 12, 13, 14, 15, 16 as 14, 15, 16, 17 and 18, respectively.

Amend Chapter VIII by creating 2 new sections, "12" and "13" as follows:

"Section 12. The Committee on Medical Defense shall consist of 5 members, appointed annually, and shall have charge of all matters pertaining to alleged malpractice of members. It shall maintain contact with the Judicial Council and refer questions of an ethical nature to that body."

"Section 13. The Committee on Insurance shall consist of 7 members, appointed annually. It shall arrange, with carriers, for various types of insurance, except professional liability, to be available to members, and covering particularly Health, Accident, Life, and Automobile. It shall supervise the application of such insurance to members of the Society."

The foregoing proposed amendments to the By-Laws to be accomplished in conformity with Chapter XV.

Respectfully submitted,
Frederic J. Quigley
J. Bennett Morrison
George H. Lathrope

Preliminary Program

MEDICAL SOCIETY OF NEW JERSEY

The 167th Annual Meeting, Haddon Hall, Atlantic City
June 6, 7, 8, 9, 1933

ANNOUNCEMENTS

Credentials and Certificates

The Committee on Credentials will meet at the hotel on Monday afternoon, June 5, and on Tuesday morning, June 6. Its office will be open constantly during the meeting.

The Constitution requires that all Fellows, Officers, Delegates, and Reporters shall register with this committee.

Delegates must present to this committee a certificate of election signed by the President and Secretary of their respective component societies. Without such certificate they cannot sit as members of the House of Delegates.

Each member of the Nominating Committee should present his certificate to the Secretary before the opening of the afternoon session so that the names of the Nominating Committee may be announced, as indicated on the program. The Nominating Committee will meet on Tuesday, June 6, at 5.30 p. m. in the Committee Room.

Papers and Reports

Papers read before this Society or appearing by title on the Official Program, whether read or not, thereby become the property of the Society. The author of each paper is required to give the Secretary a legible copy of the same *before* reading. The expense of alterations in a paper after it is in type, and the cost of illustrations are borne by the author. All manuscripts must be *typewritten, double-spaced, original copies* (carbon copies not accepted), and on one side of the paper only. Excepting orations, addresses of special guests, and the Address of the President, the time to be occupied in the actual reading of a paper is *limited absolutely to 20 minutes.* Those who formally open the discussion of any paper are allowed 10 minutes each; others 5 minutes each.

Members volunteering to present papers or reports of cases must first have their papers accepted by the Committee on Scientific Work, and then apply to the Committee on Program for an assignment of time and place on the program.

Papers and reports not presented when called for by the President cannot be presented at a later time unless and until the regular order of business is completed.

All members of Component Societies who are in good standing are entitled to attend and discuss papers in the General and in any Section scientific sessions, but have no vote in, nor the right to take part in, the discussions in the House of Delegates.

On arising to discuss a paper, the speaker will please walk forward to platform and announce his name and address clearly for the benefit of the Society. No member may speak a second time in any discussion.

All sessions will be opened promptly at the hour set, in order that the program may be carried out as planned.

The Board of Trustees will meet at the Haddon Hall Hotel, Monday, June 5, at 8 p. m.

Committees or Boards desiring meeting rooms

will please notify the Committee on Arrangements, Dr. W. D. Olmstead, Secretary.

Haddon Hall is operated on both—the American and the European—plans. The following rates are available to our members, guests and exhibitors.

Hotel Rates

The rates at Chalfonte-Haddon Hall, on the American plan are:

Rooms with bath—
1 person, $7, $8, $9 and $10 per day
2 persons, $12, $14, $16 and $18 per day

European Plan:
1 person, $3, $4, $5 and $6 per day
2 persons, $5, $6, $7 and $10 per day

American Plan, Chalfonte Hotel only:
Rooms with running water—
1 person, $5 per day
2 persons, $9 per day

Exhibits

Exhibits of instruments, books, pharmaceutic preparations, x-ray apparatus, etc., will be shown in the Exhibit Hall of the hotel, and members are urged to avail themselves of this opportunity to examine the very latest improvements in these various departments. Open 9.30 a. m. to 6 p. m.

The degree of interest shown by the visitors in these exhibits mathematically increases or decreases the revenue to the Society.

EXHIBITION

Fine Arts and Hobbies

After several futile attempts during the past 5 years to ascertain how many members of the State Medical Society might be interested in *Art* and willing to participate in an exhibition of work done by themselves and members of their respective families, success promises this time to crown our persistency; as would seem to be indicated in the following communication from Dr. C. D. Martinetti, Secretary of the recently appointed Special Committee on Exhibition of Fine Arts and Hobbies:

"A meeting was held on Tuesday, April 18, at the Academy of Medicine in Newark, of the Committee appointed by President Lippincott for the proposed Art Exhibit in conjunction with the Annual Meeting, June 6-9, 1933.

Members present were Drs. W. K. Campbell, Chairman; Ely, Johnson, Orton, Hughes, Kauffman, Martinetti and Reik.

After much discussion, a classification of exhibits was decided upon and also a plan for bringing the new exhibit to the attention of members of the Society all over the State. It was also decided that in this first venture there would be no limitation of number of exhibits submitted, and that there would be no judges and no prize awards.

The Woman's Auxiliary will be asked to form a Receiving Committee and to act as hostesses during the convention period."

The Committee is using the word—*art*—in a broad and liberal sense so that a great variety of objects may be considered as acceptable for the purposes of this particular exhibition. Paintings; engravings; etchings; drawings; sculpture; modeling, in clay or plastic material; photography—black and white, natural color, stills or movies; fancy needle-work, embroidery, etc. In the same way, the word—*hobby*—is to be considered as covering any of the things one collects or makes in accord with his or her personal enjoyment or appreciation: Indian relics; archeologic specimens; antiques of various kinds; coins; stamps; and so forth.

Arrangements will be made for safe-guarding and protecting all exhibits; those of special value will receive special care.

Every physician who is a member of the Medical Society of New Jersey, and every member of the family of such a physician, as well as those who are members of the Woman's Auxiliary to the Medical Society of New Jersey, is hereby invited to take part in this exhibition, and to place on show such specimens of his or her artistic efforts as the artist may desire or be willing to loan for the entertainment or instruction of his confreres. Proper provision will be made for the showing of lantern slides and movies (of either size—16 mm. or 35 mm.)

Please inform the Chairman, Dr. William K. Campbell, Third and Chelsea Aves., Long Branch, or the Editor, Dr. Henry O. Reik, Vermont Apts., Atlantic City, at your earliest convenience what articles you will offer, and give as much information as possible concerning their size or other factors of consequence in preparing for their showing.

HOUSE OF DELEGATES

Tuesday, June 6, 1933, at 2.30 P. M.

Call to Order.
Report of Committee on Credentials.
Reading of Minutes of 1932 Meeting.
Report of Committee on Arrangements and Program.
Report of Committee on Scientific Work.
Report of Committee on Revision of Constitution and By-Laws.
Report of Secretary.
Report of Editor and Executive Secretary.
Report of Field Secretary.
Report of Board of Trustees.
Report of Welfare Committee.
Report of Judicial Council.
Report of Treasurer.
Report of Committee on Finance and Budget.
Report of Committee on Publication.
Report of Committee on Honorary Membership.
Report of Committee on Hospitals and Medical Education.
Report of Committee on Indemnity Insurance.
Report of Committee on Group Health and Accident Insurance.
Report of Committee on Workmen's Compensation Law.
Report of Committee on Maternal Welfare.
Report of Committee on Investigation of "State Medicine".
Report of Delegates to American Medical Association.
Report of State Board of Medical Examiners.

Evening Session

Tuesday, June 6, at 8.30 P. M.

(1) Unfinished Business.
(2) New Business.

GENERAL SESSIONS

Program of Scientific Work

Wednesday, June 7, 12 Noon

The President's Address, A. Haines Lippincott, M.D.

2 P. M.

Meeting of the House of Delegates, for Election of Officers only, at 2.30 p. m.

Symposium on Urology

Arranged by A. Haines Lippincott, President of the Medical Society of New Jersey.

(1) "Chronic Non-Tuberculous Renal Infections" Alexander Randall, Philadelphia, Pa.

Discussion by: Edgar A. Ill, Newark; and C. H. DeT. Shivers, Atlantic City

(2) "Endoscopic Revision of Vesical Neck Obstructions—Its Place in the Surgery of the Prostate"
Joseph F. McCarthy, New York City
Discussion: C. R. O'Crowley, Newark; and Benjamin A. Furman, Newark

(3) "Suprapubic Prostatectomy"
Thomas C. Stellwagon, Philadelphia
Discussion: George N. J. Sommer, Trenton; and Robert Lewis McKiernan, New Brunswick

(4) "Tuberculosis of the Genito-Urinary Tract"
Stanley R. Woodruff, Jersey City
Discussion: Earle B. Stokes, East Orange; and Samuel E. Kramer, Perth Amboy

(5) "Pre-operative Gynecologic Care" (A paper for general practitioners.)
William J. Carrington, Atlantic City

Thursday, June 8, 2 P. M.

(1) "Disease of the Coronary Arteries"
David Riesman, Philadelphia

(2) "Some Phases of Electro-Cardiographic Work"
Albert S. Hyman, New York City
Lantern slides and moving pictures of recent work upon the precordial leads and its significance in relation to those *undiagnosable* types of coronary disease.
Discussion: Louis F. Bishop, Jr., New York City; Joseph B. Wolffe, Philadelphia; and Aaron E. Parsonnet, Newark

(3) "The Leukopenic States"
Asher Yaguda, Newark
Colored lantern slides—agranulocytosis, leukopenic leukemia, and other blood dyscrasias which are difficult to differentiate except hematologically. Autopsy findings in the bone marrow.

(4) "Acute Leukopenia"
D. Ward Scanlan, Atlantic City

(5) "Clinical and Pathologic Analysis of 100 Cases of Lead Poisoning"
Otto Lowy, Newark

Friday, June 9, 2 P. M.
Final Meeting of House of Delegates
General Session—2.30 P. M.

(1) "Urographic Findings in Toxemia of Pregnancy; with Lantern Slides"
R. B. Walker, New Brunswick

(2) "The Avoidable Factors in Maternal Mortality"
Philip F. Williams, Philadelphia
Discussion: S. A. Cosgrove, Jersey City; Robert MacKenzie, Asbury Park; and Albert B. Davis, Camden.

(3) "A Conference of the Maternal Welfare Commissions of the County Societies"
Arranged by A. W. Bingham, Orange, and Walt P. Conaway, Atlantic City

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SECTION ON PEDIATRICS

Chairman: Frank C. Johnson, M.D., F.A.C.P., New Brunswick, N. J.

Wednesday, June 7, 9 A. M.

(1) "Indications and Symptoms of Surgical Mastoiditis in Infants"
William J. Greenfield, Hackensack
Discussion: Kenneth Blanchard, East Orange

(2) "Public Health Responsibility of the Pediatrician"
LeRoy Wilkes

(3) "Bronchoscopy in Infancy and Early Childhood"
Henry B. Orton, Newark

(4) "The Causes and Management of Asthma in Children"
Robert A. Cooke, New York City

(5) "Recurrent Vomiting; A Clinical Study"
F. I. Krauss, Chatham

Adjournment at 12 Noon for President's Address.

Thursday, June 8, 9 A. M.

(1) "Asphyxia Neonatorum"
Arthur Heyman, Newark

(2) "The Initial Stabilization of the Juvenile Diabetic"
John Mitchell Brush, New York City

(3) "Congenital Hypertrophic Pyloric Stenosis in Infancy." Report of 30 cases.
E. G. Hummel, Camden

(4) "Abdominal Surgery in Infants and Children"
Ed. J. Donovan, New York City

(5) "Congenital Syphilis. Treatment by Oral Administration of Arsenic in the Form of Stovarsal." Report of 14 cases.
Benjamin M. Joseph, Jersey City

Friday, June 9, 9 A. M.
Joint Session with the Section of School Physicians

(1) "Ulcero-Membranous Stomatitis"
F. W. Lathrop, Plainfield

(2) "Surgical Diseases of the Upper Urinary Tract in Infants and Children"
Meredith F. Campbell, New York City

(3) "Etiology of Dyslalia"
I. J. Wolf, Paterson
Discussion: E. A. Atwood, Paterson

(4) "Scarlet Fever Prevention by Inunction with Toxin"
Maurice L. Ripps, Elizabeth

SECTION ON SCHOOL PHYSICIANS

Chairman: Allen G. Ireland, Trenton

Wednesday, June 7, 9 A. M.
Open Discussion Meeting

Chairman: Dr. Allen G. Ireland, State Department of Public Instruction

In promoting school health work the State Department of Public Instruction is mindful of the values resident in the consensus of opinion. Accordingly, this session will be devoted to discussion on certain timely questions and problems. Everyone in attendance is invited to state an opinion or observation on one or more of the following questions, which are representative of the inquiries most frequently received by the Department.

(1) What can be done to decrease the incidence of parasitic skin diseases among school children?

(2) What nutritional, mental and emotional, and pathologic conditions may we expect to find in children and youth during the next few years as results of the economic depression of 1929-33?

(3) What pre-school work may reasonably be expected of the school physician, assuming that contractural agreement is in force?

(4) What may we do to insure understanding of and coöperation in school health work on the part of the family physician?

(5) Should school physicians be licensed or certificated for school work in accordance with certain standards established by the State Board of

Education, similar to the practice in New York and Pennsylvania?

(6) Would an extension course on the school health program, offered to school physicians on a graduate basis, be well received?

(7) This session will adjourn promptly at 11.55 a. m. to hear the President's Address.

(8) What about serving milk to school children at mid-session? Who should have it, and how determined?

(9) What can be done to insure the sanitation of school kitchens and cafeterias, and to protect children from unhealthy employees and food handlers?

Thursday, June 8, 9 A. M.

(1) "Epilepsy in School Children"
Dan S. Renner, Superintendent of the Village for Epileptics at Skillman

(2) "Some Phases of Pre-school Examinations in Hackensack"
J. W. Demarest, Hackensack

(3) "A Complete Final Physical Examination for Graduating High School Students"
E. N. Huff, Englewood

(4) "Tuberculin Testing of Children"
E. H. Kleinschmidt, Director of Health Education, National Tuberculosis Association, 450 Seventh Avenue, New York

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Friday, June 9, 9 A. M.

Joint Session with Section on Pediatrics

Since several topics on the program of the Pediatric Section scheduled for this date are of prime interest to school physicians, it seems advisable to take advantage of the opportunity to participate in joint session.

EYE, EAR, NOSE AND THROAT SECTION

Chairman: Charles H. Schlichter, M.D., Elizabeth

Wednesday, June 7, 9 A. M.

(1) "Fibroma of the Pharynx"
William Brewster Allan, Englewood

(2) "Avertin Anesthesia"
V. Earl Johnson, Atlantic City

Discussion: C. D. Sinkinson, William D. Olmstead and C. Coulter Charlton, Atlantic City

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Thursday, June 8, 9 A. M.

(1) "Use of the Cross Cylinder in Refraction"
R. N. Berke, Hackensack

Discussion: J. S. Shipman, Camden; A. R. Sherman, Newark

(2) "Hyperplastic Ethmoiditis"
Dennis M. O'Brian, Passaic

Discussion: Raymond Creasy, East Orange; and G. E. Pauley, Queens Village, L. I.

(3) "Management of Vasomotor Rhinitis, from the Standpoint of the Allergist"
Lewis W. Brown, Newark

Discussion: Henry Barkhorn and Alfred Mamlet, Newark

(4) "Conservative Treatment of Chronic Suppurative Otitis Media; the Efficacy of Iodine Dusting Powder in Local Therapy"
Oram R. Kline, Camden

Discussion: Edward A. Atwood, Paterson; and James A. Fisher, Asbury Park

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Friday, June 9, 9 A. M.

(1) "Anatomy of the Temporal Bone and Its Variations"
E. B. Burtchell, New York City (By invitation)

Discussion: Jack Blumberg, Elizabeth

(2) "Perforating Wounds of the Eye"
Bernard Samuels, New York City (By invitation)

(3) "Visual Requirements for Motor Vehicle Drivers"
E. S. Sherman, Newark

SECTION ON RADIOLOGY

Chairman: Charles B. Kaighn, Atlantic City, Chairman

(The titles of the papers can not be announced in time for this publication.)

Wednesday, June 7, 9 A. M.

Diseases of the Lungs.

Thursday, June 8, 9 A. M.

Lesions of the Small Intestines.

Friday, June 9, 9 A. M.

Bone Disease Therapy.

METHOD OF PROCEDURE FOR SECTIONS OF THE MEDICAL SOCIETY OF NEW JERSEY

It shall be the duty of each Section Chairman to prepare a program for the contemplated next meeting of the Section, and to submit such program to the Chairman of the State Society's Committee on Scientific Work, for approval, at least 3 months prior to the date set by the Trustees for the next Annual Meeting. In the event that the program submitted fails to win full approval, it must be altered in such manner as the said Committee Chairman may direct, since he is responsible to the State Society for the providing of a convention program harmonious in all its parts.

For the purpose of maintaining continuity, and in accordance with the By-Laws (Chapter III, Section 1, final clause), a Chairman, to serve the Section through the following fiscal year, shall be elected by each Section at its last session during this Annual Meeting.

Inasmuch as Sections are organized primarily for the purpose of bringing together groups of members of the State Medical Society holding like interests, mostly but not necessarily practicing as specialists; and, as *the very existence* of the State Society—with its Component County Societies on the one hand, and its own unit relationship to the American Medical Association on the other—depends upon its adherence to the democratic principle of *equality* in membership; and further, because it is highly desirable that specialists may be given opportunity to learn from general practitioners—as well as that provision be made for the last mentioned class to learn from the specialists; therefore, it must be understood by all—that Section meetings must be open, at all times and in all respects, to all members of the Medical Society of New Jersey, and that all such members shall enjoy equal rights and privileges.

It should be equally well understood, of course, that with reference to Section programs—as with reference to the General Meeting programs—the *right to offer* (or the *privilege* of offering) a scientific or literary contribution does not necessarily mean its *acceptance* for the program; each and every program offering must be received and considered, but acceptance rests with the agent or agency charged with responsibility for preparation

of the program and the decision of acceptance or rejection must be based upon the merit, or the suitability, of the matter offered.

As all literary and other scientific contributions to the Sections become the property of the State Society, and will be considered with a view to publication in the Journal, contributors should carefully study, and then scrupulously comply with, the few simple rules established by the Society and the Journal's Editor. As to "papers" and "reports", those rules are:

(1) All matter for publication must be *typewritten* on *heavy* (not thin, flimsy, transparent) paper.

(2) All type-written documents must be with lines—*double-spaced.*

(3) Please do *not* use abbreviations. The Editor may find it necessary to alter your material by inserting or changing to abbreviations, but because scarcely any 2 writers employ the same list of abbreviations, and because the Journal must preserve at least the semblance of *consistency,* authors are requested to avoid use of abbreviations and to leave that prerogative to the Editor.

(4) As authority for spelling of medical words—use Dorland's Dictionary, Fifteenth Edition; for general spelling, use the Standard Dictionary.

(5) Misused words. Exercise some care in the choice of words: Do not say *case* when you mean *patient; due* when you mean *because; temperature* when you mean *fever; as* for *like;* and make some distinction between the prepositions *of* and *for; in* and *on; to* and *of;* too often these words are used as if they were synonymous.

(6) The cost of "cuts"—"electrotypes"—or other forms of illustration to be used in publication of an article must be borne by the author.

Communications

PUBLIC HEALTH COMMITTEE OFFERS SERVICE

(A letter from Dr. Stanley Nichols, Jersey Central Bldg., Asbury Park, N. J.)

At a meeting of the Public Health Committee of the New Jersey State Medical Society, a motion was made and unanimously carried, "that the Public Health Committee of the New Jersey State Medical Society offers its services for assisting in the preparation of health programs and securing proper speakers from the State Medical Society, to all State Agencies in New Jersey, having in mind programs or meetings in which any phase of health might be discussed".

This service will be gladly made available to any organization desiring it, by communicating with the Chairman of the Committee, Dr. William G. Schauffler, 21 Morven Place, Princeton, New Jersey.

DEFINITION OF "STATE MEDICINE"

(Inasmuch as many physicians are now studying economic problems which, in some instances, bring so-called "State Medicine" into consideration, we are, at the suggestion of Dr. A. C. Morgan, Ex-President of the Pennsylvania State Medical Society, republishing this A. M. A. definition.—Ed.)

In 1922, the House of Delegates of the American Medical Association adopted the following resolution which contains a definition of "State Medicine":

The American Medical Association hereby declares its opposition to all forms of "state medicine", because of the ultimate harm that would come thereby to the public weal through such form of medical practice.

"State medicine" is hereby defined for the purpose of this resolution to be: any form of medical treatment, provided, conducted, controlled or subsidized by the Federal or any State government, or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local County Medical Society, and are not disapproved by the State Medical Society of which it is a component part.

AMERICAN PROCTOLOGIC SOCIETY

The Thirty-fourth Annual Meeting of the American Proctologic Society will be held June 12-13, 1933, at the Stevens Hotel, Chicago, Illinois. More complete details may be secured from F. G. Runyeon, M.D., 1361 Perkiomen Avenue, Reading, Pa.

Woman's Auxiliary

WOMAN'S AUXILIARY
to the
AMERICAN MEDICAL ASSOCIATION

Eleventh Annual Meeting
Milwaukee
June 12-16, 1933

Headquarters: Hotel Pfister, Milwaukee, Wisconsin

(All women attending this Convention, whether Auxiliary Members or not, are invited to participate in this entire Program.)

Preliminary Program

Monday, June 12, 1933

12.30 p. m.. Luncheon at College Woman's Club in honor of Past-Presidents, followed by National Board Meeting and visit to American Medical Association Exhibits at Auditorium.
Tickets $1.00

7.00 p. m. Dinner for National Board, Delegates, and wives of Officers and Delegates of the American Medical Association at Woman's Club of Wisconsin. Musical Program furnished by Artist Members of Auxiliary to Medical Society of Milwaukee County.
Tickets $1.25

Tuesday, June 13, 1933

9.00 a. m. General Meeting, Roof Room, Hotel Pfister; Mrs. James F. Percy, presiding.

12.30 p. m. Luncheon and Bridge at the Wisconsin Club.
Tickets $1.25

2.00 p. m. *Attractions available for those not wishing to play Bridge are Layton Art Gallery, Milwaukee Art Institute, Milwaukee Museum, Curative Work Shop and Vocational School.
or
*Bus Trip to County Institutions, Milwaukee Children's Hospital Convalescent Home, and Washington Park Zoo.

8.00 p. m. General Meeting of American Medical Association.

10.00 p. m. Informal Dance at Wisconsin Club. Courtesy of State Medical Society of Wiscon-

sin. Hostesses: Woman's Auxiliary to the State Medical Society of Wisconsin.

Wednesday, June 14, 1933

9.00 a. m. General Meeting, Roof Room, Hotel Pfister; Mrs. James F. Percy, presiding.

12.30 p. m. Auxiliary Luncheon, Fern Room, Hotel Pfister. Guests and Speakers from the American Medical Association. Musical Program. Tickets $1.00

4.00 p. m. *Teas in Private Residences.

8.30 p. m. Light Opera. Tickets $1.00

Thursday, June 15, 1933

9.00 a. m. General Meeting, Roof Room, Hotel Pfister; Mrs. James Blake, presiding.

12.00 noon. Trip to Oconomowoc Lake District. Luncheon 12:30 p. m., Carnation Milk Plant, Oconomowoc, Wisconsin, Transportation and Luncheon Courtesy of Carnation Milk Company.

or

12.30 p. m. Buffet Luncheon, Crystal Room, Hotel Pfister. Tickets 75 cents

2.00 p. m. *Sight Seeing Tour of Milwaukee.

6:30 p. m. "Bring Your Husband" Dinner. Fern Room, Hotel Pfister. International-House-Cabaret. Tickets $1.50

9.00 p. m. President's Reception and Ball. Schroeder Hotel. Hosts: The American Medical Association.

Friday, June 16, 1933

10.00 a. m. Golf Tournament.

All Trips start from Hotel Pfister

*Bus Transportation to be paid by individuals.

Mrs. Rock Sleyster, General Chairman,
Wauwatosa, Wisconsin

EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey met at Bambergers' Store, at 11.30 a. m., March 13.

After luncheon, the meeting was called to order by the President, Mrs. Charles Franklin Adams.

Mrs. Orton spoke of the Widows and Orphans Pension Fund and expressed the hope that each County would secure at least 2 new members.

Mrs. Clarke asked that all bills reach her before April 2.

Mrs. Adams reminded the members that she had offered a prize to the County Auxiliary securing the greatest number of new members.

There will be an "art" or "hobby" exhibit of works by doctors and members of their families at the Annual Meeting in Atlantic City in June.

Among the members who attended the meeting were: Mrs. C. F. Adams, Mrs. George L. Orton, Mrs. John Nevin, Mrs. H. R. Van Ness, Mrs. William K. Campbell, Mrs. F. J. McCauley, Mrs. A. L. Stillwell, Mrs. William Freile, Mrs. C. B. Russell, Mrs. Harry Hubbard, Mrs. Dan Renner, Mrs. Edward Clarke, Mrs. Warren Duckett, Mrs. F. A. Kinch, Mrs. G. A. Rogers, Mrs. D. Leo Haggerty, Mrs. Hunter Scott, Mrs. A. D. Hutchinson, Mrs. James North.

Atlantic County

Reported by Mrs. James North

The Woman's Auxiliary to the Atlantic County Medical Society held its regular meeting April 7 at the home of Mrs. Joseph Poland, with 18 members present.

Plans were completed for the Annual Spring Luncheon and Bridge to be held at the Claridge Hotel on May 10; Mrs. Daniel Reyner and Mrs. James North are co-chairmen of a committee comprising Mrs. C. D. Sinkinson and Mrs. Carl Surran.

It was announced that Officers will be nominated and elected at the next meeting, to be held in the Blue Room of the Chalfonte Hotel, May 12, at 8 p. m.

Bridge and tea were enjoyed after the business session.

Bergen County

Reported by Mrs. M. M. Lynch

The Woman's Auxiliary to the Bergen County Medical Society held its monthly meeting Tuesday evening, March 14, at the Elks Club, Hackensack, with the President, Mrs. Joseph R. Morrow, in the chair.

Miss Edna Young Bond, Child Health Director of the New Jersey Tuberculosis League, was the speaker.

The previous month's meeting was held Tuesday evening, February 14, at the Oritani Field Club, in Hackensack, with Mrs. Leroy Black, Vice-President, presiding in the absence of the President.

It was decided at the Business Meeting to hold a Card Party in April to raise funds for the treasury. Mrs. W. K. Harryman was appointed Chairman of the Committee of Arrangements.

Dr. Herbert J. Stack, Instructor at Columbia and Rutgers Universities, and the National Safety Council, was the speaker; his subject being "Safety".

Burlington County

Reported by Mrs. Luther M. Hartman

Mrs. Jacob M. Davis, Mrs. John S. Conroy, of Burlington, and Mrs. Milton Shisler, of Florence, were hostesses at the reciprocity tea which the Auxiliary to the Burlington County Medical Society held February 28, at the Community House, Moorestown.

Guests, about 100 in number, are members of the Woman's Auxiliaries in Camden and Gloucester Counties, the Woman's Club in Burlington County, both senior and junior, the Y. W. C. A. and Parent-Teacher Associations.

Mrs. Luther M. Hartman, of Maple Shade, President of the Auxiliary, received with the following other officers: Mrs. Walter Zwick, of Riverside, Vice-President; Mrs. Marcus Newcomb, of Browns Mills, Treasurer, and Mrs. J. S. Hornberger, of Roebling, Secretary.

The program included a talk by Dr. I. W. Knight, of Pitman, a member of the New Jersey Health Department staff, and several numbers by Prescott Herr, of Moorestown, baritone soloist, who was accompanied by Mrs. Jonathan Powell, of Moorestown.

Camden County

Reported by Mrs. William H. Pratt

The Woman's Auxiliary to the Camden County Medical Society held its regular meeting on March 7, at the home of the President, Mrs. A. Haines Lippincott, at 2 30 p. m.

Henry O. Reik, M.D., of Atlantic City, was the first speaker. He took for his subject "Quackery". Mrs. W. Wayne Babcock, of Philadelphia, was the guest of honor. Her subject was "The Aims of the Organization and the Work Accomplished". Mrs. David F. Bentley, Jr., and Mrs. Gordan West

read papers on "The Costs of Medical Care". The Auxiliary during the past year has been helping to supply under-privileged children with glasses following the requisite examination and treatment.

Tea and a pleasant social hour closed the afternoon.

Special Meeting

A special meeting of the Auxiliary was called by the President to meet at her home on March 31 to consider the Reports on "The Costs of Medical Care", and to plan for the Annual Meeting. These reports were read by Mrs. David F. Bentley, Jr., and Mrs. Joseph Roberts and elicited a great deal of discussion among the members. A rising vote of thanks was given to Mrs. Bentley and Mrs. Roberts.

The State Nurses' Association will hold its Annual Meeting in the Walt Whitman Hotel, April 20-21. The Auxiliary decided to assist the Woman's Club of Camden in entertaining the Nurses at Tea on April 20 at 4.30 p. m.; the Woman's Club to furnish the Club House for the Tea, and the Auxiliary to furnish the refreshments; Mrs. O. W. Saunders, Hospitality Chairman, to arrange for the refreshments; Officers of both organizations to receive.

Mrs. Harold F. Westcott, of Clementon, was appointed local chairman of the Society for the Relief of Widows and Orphans of Medical Men in New Jersey.

Tea was served by our hostess and the meeting adjourned to meet on May 2.

Essex County

Reported by Mrs. George M. Rogers

On Monday, March 27, the Auxiliary held its Annual Reciprocity Meeting and Tea at the Academy of Medicine, preceded by a Luncheon to the Executive Board, at the Newark Elks' Club.

A short business meeting was held, at which a slate for the coming elections was presented by Mrs. William J. Donahue, Chairman of the Nominating Committee, as follows: President-Elect, Mrs. Don A. Epler; Vice-President, Mrs. Irving Young; Recording Secretary, Mrs. Kenneth Forsythe; Treasurer, Mrs. H. J. F. Wallhauser.

The Executive Board had previously formulated a plan to donate $75 to charity. The President presented the proposition to the organization for approval and asked opinions as to its disposition. A motion was made and carried, that the amount specified should be divided equally between the Ruth Lang Fund, of the Newark Evening News, and the Milk Fund, of the Newark Babies Hospital.

Announcements were made of the Invitation Bridge Party to be given by the Auxiliary to its members some time in June, and 2 lectures to be given at the optical laboratories of J. C. Reiss April 5 and 12. Attendance at these lectures is to net the organization about $20 for its Scholarship Fund.

Mrs. Teimer, the President, introduced Dr. James W. Howard, Assistant Director of the Essex County Juvenile Clinic, who pointed out the various ways of recognizing neurotics and of helping them to help themselves. Among many other things he stressed the following points: No physician ever cures a neurotic; instead, he must offer a prescription whereby the neurotic can cure himself; any real attempt to cure a neurotic promptly gives control of the situation to him; such patients must be met with apparent indifference; condition must be corrected by inference, not by force. One of the chief mistakes of life, he said, is a tendency to over-emphasize; this is particularly evident when men and women to whom money, social position or dress has been all-important, find these props to their personality swept away by an economic crisis and revert to symptoms as an alibi for their defeat. Neurotics are hostile to society because they feel that society is making them do the things they don't want to do; hence, they develop symptoms as a justification for not doing what the normal person does instinctively as his part in co-operative society. It is the task of the physician to make him lose this feeling of compulsion and realize that happiness is achieved only when interest in the welfare of others is aroused.

Dr. Howard reminded his audience that no child learns instinctively to be more interested in the welfare of others than of himself, and unless he is trained to that end, he will become a neurotic in adult life. It is a mistake for mothers to take children from doctor to doctor, thus arousing an interest in sickness and its possibilities for avoiding responsibilities.

Mrs. Ethel C. Taneyhill, Field Secretary for the New Jersey State Medical Society, followed Dr. Howard with a talk on "The Fourth R" in education; which she defined as "rational reactions". She said it isn't what happens to us but how we take it, that shows our rationality.

Following the meeting, the members and guests were entertained in the parlors of the Academy at tea. Mrs. Irene Brannin, harpist, rendered several delightful solos.

Gloucester County

Reported by Mrs. Henry B. Diverty

Meeting of March 16

The Woman's Auxiliary to the Gloucester County Medical Society held its regular monthly business meeting March 16, at the Oakwood Country Club at 9 p. m. The President, Mrs. Elwood Downs was in the chair, with the following members present: Mrs. Ralph K. Hollinshed, of Westville; Mrs. Chester I. Ulmer and Mrs. T. M. Gardiner, Gibbstown; Mrs. I. W. Knight, Pitman; Mrs. W. W. Pedrick, Glassboro; Mrs. Baxter Livengood, Swedesboro; Mrs. Irving J. Stewart, Swedesboro; Mrs. William Brewer, Mrs. J. Harris Underwood, Mrs. Paul M. Pegau, Mrs. Ralph L. Moore, Mrs. Henry B. Diverty, of Woodbury; Mrs. H. G. Miller, of Millville, guest.

After the business meeting a social hour followed. The County Society was in session at the same place, and at the close of its meeting the women joined the men in the dining room, where a fine collation was served.

Meeting of March 22

The Woman's Auxiliary to the Gloucester County Medical Society held Program Day on March 22, at 2.30 p. m., at the home of Dr. and Mrs. J. Harris Underwood, Woodbury.

Invitations were issued to the members of the Auxiliary with privilege of bringing guests to hear Mrs. Joseph Richard, of Philadelphia, speak on "Russia".

Mr. Richard is an engineer. When his work called him to Russia, his wife and 2 daughters, 8 and 10 years of age, accompanied him. They remained about 4 years. Mrs. Richard is a well educated and polished speaker. Dressed in the costume of a Russian peasant, and a suitcase full of souvenirs from Russia, she spoke to us in our own language and then at once followed with the Russian tongue and manner, which made her talk doubly interesting. There were 60 to 80 women listening intently to the last word.

Tea was poured by Mrs. William Brewer and Mrs. William Crain. The younger members of the Auxiliary served. The audience was composed of friends of the Auxiliary members, coming from Camden, Berlin, Mt. Ephraim, Wenonah, Swedesboro and Woodbury.

SPRING MEETING

The Woman's Auxiliary to the Gloucester County Medical Society held its Spring meeting at the Oakwood Country Club on Thursday, April 13, at 9 p. m. The Gloucester County Medical men and their wives were invited guests.

The speaker of the evening was Dr. Ivor Griffith, a Professor of Chemistry and Editor of The American Journal of Pharmacy. Mrs. Griffith accompanied him.

The address was followed by a musical program with vocal solos by the following: Mrs. William Crain, of Mt. Ephraim; Dr. Sinexon, of Paulsboro, and Miss Ethel Crain, of Mt. Ephraim, all of which were greatly appreciated by the audience.

At the conclusion of the program, Mrs. Elwood E. Downs, President of the Woman's Auxiliary, invited all into the dining room, where a fine collation was served by the proprietor of the Country Club.

Hudson County

Reported by Mrs. James Murphy

MARCH MEETING

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on March 6, at the Y. W. C. A., with the President, Mrs. George M. Culver, presiding; about 40 members and guests were present.

The President appointed the Nominating Committee for the Spring election, as follows: Mrs. Frank Nicholson, Chairman; Mrs. Warren Duckett; Mrs. Arthur Largay; Mrs. William Freile; and Mrs. John Nevin.

It was moved, seconded and carried that the April meeting be a Card Party, to help swell our funds for charity—a Dessert-Bridge, beginning at 12.30.

The speaker for the afternoon was Mrs. Ethel C. Taneyhill, Field Secretary of the Medical Society of New Jersey; her subject: "You Are What You Eat". In her own inimitable way, she told us many interesting and instructive things, and every one agreed that it had been a most enjoyable afternoon, and Mrs. Taneyhill was given a rising vote of thanks.

During the tea hour that followed there was an informal discussion, when many questions were asked and answered.

Before the meeting, the President, Mrs. George Culver, entertained Mrs. Taneyhill at lunch, her other guests being Mrs. William Freile and Mrs. John Nevin, former Presidents of the Auxiliary.

APRIL MEETING

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on Monday afternoon, April 3, at the Y. W. C. A., Fairmount Avenue, with the President, Mrs. George M. Culver, in charge.

The only business transacted was to change the date of the next meeting, which will be our Reciprocity Meeting, to May 8, instead of the first Monday.

The April meeting took the form of a Dessert-Bridge, commencing at 1.30 p. m., and given to swell our Charity Fund.

Mrs. William Frelle, Temporary Chairman of the Entertainment Committee, with her able committee assistants, provided an enjoyable afternoon, and each table was rewarded with a dainty souvenir.

Somerset County

Reported by Mrs. E. A. Levy

A regular meeting of the Woman's Auxiliary to the Somerset County Medical Society was held at the Nurses' Home of the Somerset County Hospital. In the absence of the President, Mrs. Meigh, the Vice-President, Mrs. Stillwell, presided.

The reports of the Treasurer and of the various standing committees were read. A Nominating Committee was appointed to prepare for the annual election in April.

At this meeting, news reached the organization of the recent death of one of its charter members, Mrs. J. Howard Cooper, who succumbed after a serious illness. A tribute to her memory, written by Mrs. Stillwell and Mrs. Ely, was read by the Secretary, and a copy of this tribute was sent to Dr. Cooper, and to the local press.

Upon motion the meeting was adjourned.

Union County

Reported by Mrs. Frederick A. Kinch

The Annual Meeting of this Society was held Wednesday evening, April 12, at the home of Mrs. H. V. Hubbard, Plainfield.

According to our Constitution, only a part of our Officers are elected each year. This year, the following Officers assumed their duties: President, Mrs. Harry H. Bowles, Summit; Vice-President, Mrs. Friend B. Gilpin, Cranford; Recording Secretary, Mrs. George A. Seymour, Elizabeth; Treasurer, Mrs. George S. Laird, Westfield; and 2 Directors, Mrs. Charles H. Schlichter and Mrs. P. DuBois Bunting, Elizabeth.

The retiring President, Mrs. Harold D. Corbusier, Plainfield, in her usual gracious manner, welcomed the Incoming-President, Mrs. Bowles, who in taking the chair spoke of the aims of the Auxiliary; first, to support the ideals of the County Society; and, second, to promote sociability among the members of the organization.

The Chairmen of the following committees were announced: Program, Mrs. George L. Orton, Rahway; Publicity, Mrs. Frederick A. Kinch, Westfield. Delegates appointed to the State Convention were Mrs. George S. Laird, Westfield; and Mrs. P. DuBois Bunting, Elizabeth.

For the program of the evening, different members were asked to tell of an unusual vacation or of some hobby. Mrs. H. V. Hubbard showed pictures of the Byrd Expedition to the South Pole, Little America; and also told of the restoration of Williamsburg, Virginia, seat of William and Mary's College, to its Colonial style, through the generosity of Mr. John D. Rockefeller.

Mrs. George S. Laird gave a graphic description of Crater Lake, Oregon, and exhibited some handmade jewelry.

The Retiring-President, Mrs. Harold D. Corbusier, sails to Europe in May, and regrets her inability to attend the State Meeting in June and to give her report, having the distinction of holding 3 Annual Meetings the past year, in order to conform with the request of the State Society as to the date of the Annual Meeting. A vote of thanks was extended to Mrs. Corbusier for her interest in the activities of the Society the past year.

Refreshments were served by the hostess, and all present voted it a most enjoyable and entertaining evening.

County Society Reports

ATLANTIC COUNTY

L. M. Walker, M.D., Reporter

MARCH MEETING

The regular meeting of the Atlantic County Medical Society was held March 10 at the Chalfonte Hotel, with 40 members present.

Dr. W. B. Stewart stated that he was sorry to have learned that Dr. Williard Mason had become interested in the Hoxie Cancer Cure and was aiding in the establishment of such an institution in Atlantic City.

Dr. Conaway suggested that a group of the older members call upon him and try to reason with him against proceeding further.

Dr. Carrington said that he had talked to him but with no results.

A committee was appointed, comprising Drs. Conaway, Allman and Darnall, to call on Dr. Mason for the purpose already stated.

Dr. Stewart also mentioned the possibility of the 1934 meeting of the A. M. A. being held in Atlantic City and urged every member to do all he could toward securing this Convention. He said he had dropped a hint at the meeting of the American College of Physicians and found that nearly everyone was in favor of coming here.

The Scientific Program for the New Jersey State Medical Society's 167th Annual Meeting, to be held in June, Dr. Stewart said, had been completed with an excellent set of papers. The first day will be taken up by President Lippincott's selection of speakers to present Genito-Urinary Subjects; the second day, by Dr. Riesman, on Affections of the Heart and Blood, and Dr. Scanlan (topic not stated); and the third day, with a Symposium on Obstetrics, arranged for by Dr. Conaway.

The General Meetings will be held in the afternoon and Special Sessions in the mornings so there will be no over-lapping.

There will be no Scientific Exhibit this year because the A. M. A. Convention directly following our New Jersey Society Meeting makes transportation of the material too difficult.

Dr. Stewart mentioned that there has been some talk of the Canadian Medical Association meeting here with the A. M. A. in 1934.

Dr. Shivers stated that he had talked with Mr. Richman, of the Convention Bureau, and had been to Chicago to see Secretary Olin West of the A. M. A., and conditions seem favorable to Atlantic City for the 1934 meeting.

Dr. Darnall called the attention of the members to the list of new books in the monthly Bulletin which have been added to the Medical Branch Library.

Dr. Carrington stated that the quota for the Course of Post-Graduate Lectures on Medicine had been more than filled, but only 6 or 8 had so far registered for the Neurology Course.

Dr. Harley said that he knew Dr. Spiegal as an excellent neurologist and teacher and he urged the members to take this course if at all possible. He hoped that 20 men would be able to enroll.

Dr. Conaway stated that there had been 2 radio broadcasts, by Drs. Kilduffe and Irvin, and that there would be 2 more soon.

Dr. Reyner said the Entertainment Committee had not made any definite arrangements for the Annual Outing but that Drs. Davidson, Mason and Uzzell had extended an invitation to hold it at "Dox Folly". This was accepted with appreciation. Dr. Reyner suggested that the ladies be invited to this outing; a suggestion that was left for the Committee to decide.

The application of Dr. Joseph P. Cleary, of Minnetola, was referred to the Board of Censors.

A letter from the Mead Johnson Co., offering to show various motion pictures before the County Society Meetings, was read and filed.

The Scientific Program was presented by Dr. John F. Erdmann, Professor of Surgery, Columbia University, and Director and Visiting Surgeon, Post-Graduate Hospital, New York City, on "The Recognition and Treatment of Postoperative Complications".

Postoperative shock and collapse may be due to hemorrhage or trauma to tissues. Hemorrhage is treated by transfusion, infusion and subcutaneous injection of salt solution with glucose. Shock due to nerve trauma is best treated with morphia. Evidences of hemorrhage are: steady increase in pulse rate, pallor, the staring eye, air hunger and restlessness. In operations for biliary conditions the coagulation time may aid in diagnosing concealed hemorrhage.

Decreased urinary output may be an early complication recognizable by careful measurement of the urine. It may be due to retention in the bladder, to partial or complete suppression, or to traumatic retention, as is seen after injury to one or both ureters. Retention in the bladder may be revealed by catheterization. Suppression calls for fluid, by mouth, intravenous infusion, subcutaneous injection, or by frequent small retention enemas of normal salt solution and water.

Chest complications are: purulent bronchorrhea, pneumonia, pleurisy, and pulmonary collapse. These, and also cardiac complications, are recognized by the signs presented, and must have appropriate medical treatment. Bronchoscopic treatment for pulmonary collapse, is of value.

The abdominal complications most frequently met with are: hiccough, vomiting, gastric dilatation, dehiscence or evisceration, spastic paralysis, and peritonitis with paralysis or obstruction.

In hiccough, the surgeon must be sure about the patient's urine, his blood chemistry, and the absence of infection. Carbon dioxide and oxygen inhalations may be of use. There is often a spontaneous cessation between the ninth and eleventh days. Intervals of rest should be obtained with anodynes and narcotics. The physical condition must be kept up with food and fluids by subcutaneous, intravenous and rectal routes. Phrenic operations are rarely necessary.

Vomiting, if persistent, may be relieved by autolavage or lavage with a Levine or Jutte tube. If it continues, a Levine or Jutte tube is introduced through a nostril and left in the stomach for several days. Water and weak tea may be given by mouth, with the tube in place. The tube is also useful in gastric dilatation.

In gastric dilatation, early diagnosis is important. The first symptom is the effortless regurgitation of a mouthful of watery fluid. Later, occasional greenish or black streaks are observed in the expectoration. There may be some distress or unrest in the stomach, and a definite distention in the epigastrium is sometimes seen. The eyes become sunken, the facial skin retracts, there is an anxious expression, and then there may be an explosive vomiting of a large quantity of greenish or brownish fluid. The treatment consists of constant washings of the stomach and the tube should be left in until the return flow has remained clear for 24 to 48 hours. Strength is sustained by venous, rectal and subcutaneous fluids.

Dehiscence of the sutured tissues and evisceration occur in about .5% of abdominal operations. It may be due to tissue hunger, catgut, poor apposition, fat interposition; and with additional postoperative features such as coughing and sneezing.

Weakened physical condition causes tissue hunger with resulting digestion of catgut before healing has taken place. Dehiscence may be prevented by getting the patient into the best possible physical condition before operation; by careful suturing of the tissues in layers; and by strengthening the repair with retention sutures. The wound usually heals very rapidly after the evisceration is reduced and the incision resutured.

Peritonitis may, rarely, occur in supposedly asceptic operations: due to soiling of the peritoneum in acute appendicitis; perforation in other viscera; introduction of a foreign body without injury to any of the hollow viscera, as in bullet or stab wounds; rough handling of the viscera; traumatization and destruction of blood supply, with resulting perforation and the soiling of the peritoneum in supposedly clean work, as seen occasionally in pelvic operations. The symptoms are pain, fever, rapid pulse, distention, vomiting, and anxious expression. The value of an enterostomy, as treatment, is doubtful since as much can usually be done by introducing a Jutte or Levine tube.

Intestinal obstruction without infection is not usually recognized as early as it should be, and the operator frequently fears to re-enter the abdomen. If there is doubt, the abdomen should be re-opened at once, rather than waiting until it is too late to be helpful. These obstructions may be due to angulating adhesions; early-formed bands; herniation through gaps in the mesentery; and, foreign bodies inducing adhesions. The symptoms are cramp-colic, nausea, vomiting, rapid pulse, rise in temperature, change in the character of the vomitus, and dehydration. The flat radiograph may help greatly in making the diagnosis. In treatment, the earlier the operation, the more sure are we of recovery.

Fecal impactions usually occur in women past 55 years old. There may be daily bowel movements but the patient complains of distress, and pain in the lower bowel. The diagnosis is made by digital examination. Treatment is a retention enema of olive oil followed by one of molasses. If this fails, spooning out of the mass is indicated.

Alkalosis may result from using alkaline enemas. The diagnosis is made by blood examination. Acidosis may occur after a long siege of vomiting. The treatment is, free use of infusions and fluids and the administration of alkalis and glucose.

Pseudo-obstruction may occur as the result of trauma to the lumbar plexus, and it clears up spontaneously.

High temperatures usually occur in urinary tract infections, erysipelas, pneumonia and following transfusions or infusions. Urinary infections will usually clear up in 7 to 10 days if large amounts of fluids are given without any internal or local treatment. MacNeal, of the Post-Graduate Hospital Pathologic Laboratory, has claimed some success in limiting the disease by the use of bacteriophage.

Infections include those of the wound, metastatic abscesses of the liver, and perirenal tissue. They are located by radiograph, aspirating needle, or exploration. Negative blood cultures are not of much significance. Infections of the fascial planes adjacent to the wound are important and may spread rapidly and with a high mortality. The treatment is early drainage with liberal incisions.

Phlebitis may follow any abdominal operation. The left lower extremity is usually involved; the most positive sign or symptom being pain deep in the calf of the leg. This is followed by edema and swelling, then pain at the knee and in the groin. Phlebitis usually occurs before the tenth postoperative day, and the treatment is rest, ice-bags and anodynes.

Embolic gangrene occasionally occurs in an extremity and usually necessitates amputation. Embolectomy rarely effects good results. Embolic thrombi that involve the cardiorespiratory system are almost always immediately fatal.

Coma may be of the renal type or may be due to diabetes or to the biliary tract. Each is characteristic, and presents a definite picture as to treatment. Transfusions of whole blood are indicated when the hemoglobin is under 50%.

Infusions are of the utmost importance in sustaining life, and for washing out poisons or diluting them in the blood stream. The same may be said of hypodermoclysis. Rectal instillations of 3 oz. of salt solution and 3 oz. of tap water, q. 4 h., is also advisable.

The operator with the lowest mortality rate and the smoothest recoveries is the one who has his eye and ear upon his patient constantly; provided that he appreciates the subtle onsets of many of the complications mentioned in this communication.

Dr. Senseman: I find myself in a very uncomfortable position, as anyone must if asked to discuss a paper by Dr. Erdmann. If anything was left out, I don't know what it was. And I have but one thing to offer, which may be a reiteration, and that is that many postoperative findings are started at the operating table. The most frightening one is the so-called secondary abscess following operation, and which I believe should be called a secondary collection of pus due to an error in the institution of drainage and the care of the drainage tube when the patient is back in his bed. I always feel somewhat guilty in these instances.

One other serious complication is the stitch-abscess, which I think is a misnomer. In a large number of cases where there is a wound abscess the patient goes along with a normal temperature at first and then it goes up, slowly, and looking at the wound, in 2 or 3 days a little swelling appears and, using a probe, pus is found. They are outside the fascia and due to 1 of 2 things: contamination of the fat, which is very easy; and, a wet wound. Anybody who leaves a wet wound invites infection. This is especially true in herniotomies.

Dr. Darnall: Certainly, Dr. Erdmann has covered the ground very comprehensively. I do think that the success of taking care of these post-operative complications is largely dependent upon their early recognition. The man who has his eyes open, and is watching his patient for the earliest clue, is going to be more successful than those who wait 2 or 3 days. Early recognition is borne of long experience and plenty of hard knocks.

I think, however, that in the last 20 years our postoperative complications have become very much fewer than they were previously. I remember that we had a much more thorny road to travel then, than now.

Shock, acute dilatation of the stomach, abdominal fistulas and secondary hemorrhage are much less common-place than of old, for which there are a great many reasons. We conserve the patient's blood, so that not one drop is lost; our anesthesia is given as chosen for each particular patient; and such details have a great deal to do with preventing shock and acute dilatations.

Dr. Allman: I just want to say that I certainly enjoyed the "parade of the ghosts"—and they are that to every surgeon—and anyone who has done enough surgery has had all these things happen.

Prophylaxis plays the most important rôle in the prevention of these complications. Regardless of how skilled or how careful we are, we sometimes see such complications when we least expected them.

Dr. Silvers: Dr. Erdmann has given us a detailed

account of the postoperative complications, and has pointed out so clearly that the surgeon's duty is not finished when he stopped operating. The mere mechanical procedure is not the whole thing—for his responsibility is equally as great after the operation.

Dr. Carrington: We recently had a patient with acute dilatation after hysterectomy, and after turning her over on the abdomen she got much relief. In 3 instances, where the wound broke down, we found that all 3 patients had syphilis.

Dr. Johnson: Some few years ago I had the privilege of serving as a Resident Surgeon at the Post-Graduate Hospital. At that time, I was very much impressed with Dr. Erdmann's enthusiasm and capacity for surgery. Anyone who has been in Dr. Erdmann's clinic, who has seen him at work in his amphitheater, is impressed that the Master is at his job. Since serving as a resident there, I have had the opportunity to go back several times to see him and I always come away with new enthusiasm.

I have always been most interested in getting my patients well, and postoperative treatment is an important part of that.

I have never been able to figure which was most important—pre-operative or postoperative care, but I do feel that the postoperative complications may be mitigated by proper evaluation of the patient beforehand.

There are 5 things we should learn about the patient before operating:

(1) Proper diagnosis, eliminating a lot of exploratory work and the avoidance of operating in the upper abdomen because of possible epigastric symptoms in tuberculosis.

(2) Evaluation of the condition of parenchymatous organs—where there are many things to be considered.

(3) Determination of what concurrent diseases may be present.

(4) Elimination of purgation before operation; it is always an irritation and at times causes more trouble and more complications.

(5) What kind of anesthesia? This very frequently makes a difference as to the course of events after operation. Avertin, in certain nervous patients, will eliminate a certain type of shock.

Dr. Darnall: I reported a series of cases where the incision was apparently in good condition on the tenth day but when the stitches were taken out the wound fell right open. My contention was that this was probably due to syphilis. I would like to ask Dr. Erdmann if he has made any investigations along that line and what he thinks about it.

Dr. Subin: I certainly appreciate what Dr. Erdmann has told us about postoperative complications and, believing as I do, that these are usually relegated to the young men, it has certainly been a treat to me.

Dr. Erdmann: I certainly feel very gratified to have such a thorough discussion. I feel that syphilis is the last question as a pre-operative consideration. I have had a number of patients with dehiscence, of whom not one has had a +4 Wassermann, but you could see the catgut being eaten away. With dehiscence, we cannot sew up the wound a second time in layers, as it is mushy, but have to do through and through sutures.

April Meeting

The regular meeting of the Atlantic County Medical Society was held April 14 at the Chalfonte Hotel, with 38 members present.

Dr. Stewart reported that there will be a Scientific Exhibit at the State Society's Annual Meeting; a recent change of plans.

He also stated that he had received several anonymous letters with regard to "a nurse" who is alleged to have been giving some forms of treatment which are against the State laws, but it is impossible to do anything if the informers will not sign their letters.

With regard to the Hoxie Cancer Cure, Dr. Stewart said the Chamber of Commerce is doing all it can to get rid of this menace. Dr. Bloodgood has written the Chamber of Commerce a letter denying any connection with or endorsement of such methods, and expressing great annoyance at the use of his name. He said if something was not done with the "Cure" before long he will institute legal proceedings to keep them from bringing his name into their schemes.

Dr. Carrington reported that the first Course of the Post-Graduate Lectures had been completed and that the next will begin Wednesday, April 19; a "Course in Neurology" to be given by Dr. Spiegel. Physicians from Cape May and Camden Counties and from New Egypt will help to make up the quota.

Dr. Conaway reported that there will be 2 Broadcasts in the near future by members of the Society, from Station WPG.

Dr. Reyner reported that the Entertainment Committee has decided to have the "Annual Outing", at Dox Folly, in June, the exact date to be set later. He asked for an expression of opinion as to inviting the ladies, and it was decided that it would depend largely on the banking situation, whether funds are available at that time.

Dr. Irvin will send letters to all members to get in touch with the Delegates to the A. M. A., and have them work for the acceptance of our invitation for the meeting of 1934.

The application for membership of Dr. M. B. Holoman was referred to the Board of Censors for action, as was also a letter from the Credit Bureau of Atlantic City.

The Scientific Program was presented by Drs. W. H. MacKinney, Professor of Urology, Graduate School of Medicine, University of Pennsylvania, on "Suprapubic Prostatectomy, Including Pre-operative and Postoperative Treatment"; and by Clyde W. Collings, Instructor in Urology and Chief of Clinic, New York University Medical School, and Visiting Surgeon to Bellevue Hospital, New York City, on "The Plight of the Prostatic". (Papers to appear in the Journal when space permits.)

The Nature, Prophylaxis and Treatment of Poliomyelitis

John A. Kolmer, M.D.,
Philadelphia, Pa.

(Dr. Kolmer read this paper at the January meeting, and it was to have been abstracted for the February Journal but did not reach us in time for publication there-in. We then assigned it to the March issue because it fitted into the Symposium among Original Articles, but it was displaced at the last moment by an urgent demand for space. We consider it, however, of sufficient value to justify its publication even this far away from its proper place.—Ed.)

Before considering the more definite part of the address this evening, on the "Prevention and Treatment of Poliomyelitis", we may with profit review some of the prevalent views on the etiology and general features of the disease.

Personally, I do not know of any disease better calculated to strike terror in the hearts of parents than poliomyelitis, because of the feeling that we are dealing with a disease beyond our control,

and also because there is so much about poliomyelitis that we do not yet understand.

Of course we all realize that the term "infantile paralysis" is a misnomer, because it is not confined to childhood but may be found in adults although it is true that the majority of cases occur in children under 10 years of age. Possibly "poliomyelitis" is a *better* name but we are still lacking a *proper* one for this disease.

There is a general consensus of opinion that poliomyelitis is due to a filterable virus—an extremely small organism capable of passing through a very dense filter. Rosenow's claim that it might be due to a streptococcus is receiving little support. There is no denial of the fact that a streptococcus can be found in the brain and spinal cord of those human beings whose death it has caused. It is believed, however, that the streptococcus is a secondary invader and not the primary cause. We have had no difficulty in isolating streptococci but while Rosenow claims that they will produce poliomyelitis, others, including myself, have been unable to confirm his observations.

Poliomyelitis is regarded, therefore, as due to a filterable virus and not to streptococci. A curious thing about the virus is that it is very easily destroyed in the outside world, so that we have every reason to believe that it is transmitted by direct contact. Furthermore, the virus is easily destroyed by germicides but has a very peculiar resistance to carbolic acid. It may survive 4 to 6 hours in 5% solution; which no spore-bearing bacteria could stand.

Some years ago Noguchi and Flexner, trying to cultivate the virus, concluded that the "globoid bodies" they found constituted the cause, and Heist and I, in Philadelphia, got these same globoid bodies in cultures; but it has since been proved that they are not, really, the virus of poliomyelitis, so we must still say that the virus has not been successfully cultivated.

Probably the virus never will be cultivated in what is known as "dead media", for it is apparently true of this virus, as of all others, that it will only grow in a living cell, and will not proliferate except within living cells. It can be cultivated *in vitro* but not on such ordinary culture media as we now have for growing bacteria.

This is greatly to be regretted, because it reduces the chances of devising a successful means of vaccinating against the disease.

Among the lower animals, only the monkey is susceptible. All attempts to infect the rabbit, guinea-pig, mouse, rat, dog and cat, have failed. This is greatly to be regretted because it hampers research in this disease on account of the expense involved. Only the large, well-endowed laboratories can afford the expensive research needed; otherwise, we would be much further along in our knowledge of poliomyelitis.

Apparently, the virus enters the body through the nose and throat, though it may occasionally enter through the gastro-intestinal tract; and there have been 2 epidemics in New York City that were almost certainly milk borne. Curiously enough, one cannot produce poliomyelitis in the monkey by feeding it the virus, but we have reason to believe that human beings are sometimes infected by swallowing the virus in food or in water, because there is a good deal about the pathology of poliomyelitis to suggest the possibility of the virus entering the abdominal lymphatics in a manner similar to the mode of infection in typhoid fever.

The truth of the matter is—we are not certain but it seems most likely that the avenue of infection is generally the respiratory tract. Some believe that the disease may be transmitted by flies and vermin, a theory based on the prevalence of the disease in August and September, during hot weather; but, although the disease does occur in the warm months of the year in our Northern States, it is almost unknown in our Southern States. So, it probably is not an insect borne disease.

No disease has been more puzzling in its epidemiology than poliomyelitis; by which, I mean to say the frequency with which cases will develop in isolated families, or in isolated spots, without our being able to trace any possible connection with a source of infection. Of course, I think most students believe that the virus is spread to a greater extent by carriers than by contact with known patients. Another curious thing is that second cases in the same family are rather exceptional. That does not mean that 2 or 3 children may not become infected, but it is rather curious that when 2, 3 or more members of a family are stricken they practically all go down at the same time.

The virus of poliomyelitis has been found in the secretions of the nose and throat, in the central nervous system, and in the stools of patients with the disease, but not in the blood and only rarely in the spinal fluid. Just how it reaches the spinal cord and brain from the nose and throat is still a matter of conjecture.

It may be that the virus travels up the lymphatics of the nerves to the base of the brain where it is distributed to the central nervous system. Entering the lymphatics from the blood supply in the nose and throat, does it reach the brain by a hematogenous route? This is uncertain. May it get into the nose and throat, be swallowed, taken into the abdominal lymphatics, and, thence reach the spinal cord and brain by a lymphatic distribution? There is a good deal in the pathology of poliomyelitis to support this point of view; the only drawback being that no one seems yet to have produced the disease in the monkey by feeding the virus.

Ever since Wickman, of Sweden, described the abortive type of poliomyelitis, this particular human type has attracted a great deal of attention, and some competent observers believe that poliomyelitis may masquerade in an abortive form, without production of paralysis, and be recognized during an epidemic because we are then on the alert, but I do not know how we are going to detect such cases in normal times, when the incidence is within normal limits. This abortive type is, in children, usually expressed clinically by an elevation in temperature; some soreness of the throat; gastro-intestinal symptoms, like an "upset stomach"; possibly diarrhea; and some change in temperament. Stiffness of the spine is particularly characteristic and the neck may be rather rigid.

It is the correct thing to make an examination of the spinal fluid whenever the disease is suspected. Spinal puncture does no harm, but we must remember that when it is conducted the most important laboratory examination is *a total cell count* which must be made as quickly as possible after the spinal fluid has been withdrawn. The best plan is, to take the microscope into the bedroom and *make the count immediately after the fluid has been withdrawn.* A moderate increase is of diagnostic importance—allowing 5 to 8 cells per c.c. as normal.

Diagnosis must still depend largely upon the alertness and experience of the physician, in detecting the symptoms and early signs of muscular weakness and paralysis, supplemented by spinal fluid examination. One attack of poliomyelitis usually confers an immunity for the balance of life.

There is no doubt now that 60-70% of normal adults have something in their blood that will neutralize the virus of poliomyelitis, but, we are be-

ginning to question whether or not this antibody is the result of poliomyelitis in childhood. This naturally brings up the question of using serum for the prophylaxis and treatment of the disease. It is very difficult to express an opinion on the value of the convalescent and normal serums, and very difficult to express an opinion on the curative properties of the serum, but I am personally convinced that the injection of convalescent serum will give the human being a certain amount of protection against the disease.

How long will immunity last after the injection of convalescent serum? As far as the monkey is concerned it does not endure more than a few weeks. Probably it will last longer in the child than in the monkey because the child is being injected with a homologous serum and will not eliminate the serum as quickly as does the monkey injected with human serum. I would hazard a guess of about 4 to 6 weeks.

I have never injected children, for prophylactic purposes, with the blood or serum of their parents, though I presume the method is worthy of trial. If employed, we should inject the blood of both parents. To depend upon one, is running a 30-40% chance that the blood has no protective value for the child.

As far as I know, treating poliomyelitis with convalescent serum has not materially influenced the mortality rate, but I have the impression that one cannot evaluate the value of serum in the treatment of the disease by statistics. I believe that the early administration of adequate amounts of serum has, in many cases, limited progress of the spinal cord lesions, and I agree with those who say that convalescent serum is of doubtful value in treatment after paralysis is well pronounced.

Our knowledge is still at the point where we have to express an opinion of the value of serum treatment on the basis of personal experience. I believe that the proper thing to do in treatment is to give the serum before the paralysis has become serious—as early as possible and in large doses.

Never dribble the dosage of serum in any disease —diphtheria, lockjaw, meningitis, pneumonia—the principle is always the same. Try to give the patient enough serum in the first 2 or 3 days. The average patient will need 80-100 c.c. I do not know what to say about normal serum, as I have never felt justified in using it; because, with proper effort one can usually obtain convalescent serum. There are those who think normal serum just as valuable but I personally doubt this and prefer to use convalescent serum.

I know of no specific drug or chemical agent for treatment of this disease, and treatment other than with serum is symptomatic.

BERGEN COUNTY

Charles H. Littwin, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held Tuesday evening, March 14, at the Elks' Club, Hackensack.

After a short business meeting, the Chairman called on Dr. Littwin to present on behalf of the Society, to Dr. J. Finley Bell, a Dressing Robe, to commemorate the "Fiftieth Anniversary" of his practice of medicine. Report of this event appeared in the April Journal.

The Scientific Program follows:

Dr. Aaron Parsonnet, of Newark, spoke on the "Failing Heart of Middle Life", and *Dr. LeRoy Black*, of Rutherford, gave a 10-minute talk on "Coronary Disease".

Dr. Parsonnet, summarizing his paper, spoke as follows: "This by no means exhaustive survey merely attempts to outline the early symptoms of myocardosis. We have sought to trace this condition through the remote general symptoms, which develop more or less insidiously in most individuals approaching middle life. Practically all of the symptoms are subjective in character and are brought out in true relief only by the skill and care displayed by the examiner in eliciting the many subtle changes which may occur when the cardiovascular system begins to show signs of losing its functional integrity. We have previously pointed out how pains-taking such a history must be, and how elusive, and how easily over-looked some of these symptoms may be. A review of these symptoms under a discussion of easy fatigability, insomnia, personality changes, anorexia, gastro-intestinal disturbances, and decline of the individual's ambition in general, all indicate the intangibility of the subjective phenomena occurring in the early stages of myocardosis.

We have considered the great triad of symptoms referable to the cardiovascular system itself, and the part that dyspnea, substernal discomfort, and palpitation play in completing a presumptive diagnosis established by purely subjective symptomatology. We have purposely refrained from mentioning the positive findings in the physical examination of such individuals; when the electrocardiograph, radiograph, or other laboratory procedures yield evidence of cardiovascular damage, such patients can no longer be consideerd as coming within the definition of early myocardosis.

We have attempted, in short, to develop the syndrome of early myocardosis as one in which the ordinary methods of examination are generally negative or inconclusive and yet, at the same time, we suspect that something is wrong with the patient. Into this group come thousands of individuals who pass life insurance examinations without difficulty, and who are turned out of the average consulting room with a negative notation on the record, but who, sad to say, subsequently develop severe and unmistakable heart disease.

The prognosis in myocardosis seems to depend on its age incidence; the earlier it appears, the more serious the outcome. When it is seen in the late thirties or early forties, it may be rapidly fatal; the patient even dying during his first stenocardial attack. Postmortem examination may reveal little or no pathologic change, the stenocardia apparently being a physiologic process of such short duration that no concomitant anatomic change has taken place.

When the symptoms of myocardosis develop in the next decade, the prognosis must still be very guarded. The patient may have several months or even a few years of stenocardial symptoms before the final fatal attack; for postmortem examination frequently discloses definite coronary arterial changes with the associated myocardial damage manifest in areas of myofibrosis. Paradoxically, when the symptoms of myocardosis develop in the sixth or seventh decades, the prognosis is much better; extensive coronary disease with considerable areas of myosclerosis and infraction may occur. Aneurysmal dilatations of the heart wall, extensive scarring and even calcification of the myocardium may be present, and yet the patient may have had very few symptoms. This paradox is explained through the work shown by Gross that, the older the heart the greater the capillary circulation. Moreover, the decreasing demands made upon the heart in the later decades of life, in contradistinction to those necessary in the

fourth and fifth decades, may also be an important factor in explaining the above paradox.

The emphasis formerly placed on the valvular diseases of the heart is rapidly giving way to the conception of myocardial efficiency, and the presence or absence of murmurs is no longer regarded as one of the fundamental criteria in cardiovascular prognosis. In considering the causes of death from heart disease, age incidence is important; in the first 3 or 4 decades of life, the inflammatory types are preeminent, while in the latter half the noninflammatory group takes precedence. In other words, myocarditis, regardless of its etiology, is a disease of youth. Myocardosis, on the other hand, is the result of the gradually aging process and represents the degenerative changes that take place in the heart with advancing years.

The rôle played by myocarditis of the youthful heart, in predisposing toward myocardosis of the older one, remains one of the many problems in cardiology still to be investigated.

In thus introducing the word *myocardosis* we have attempted to distinguish between the inflammatory and the noninflammatory types of heart disease considered in their broader sense. In limiting the term *myocarditis* to those types of heart disease in which the elements of inflammation are present in one form or another, the term myocardosis seems to fill a logical need, if we are to keep abreast of the modern concepts of cardiovascular disorders.

In spite of all that was said, however, we shall find no fault with the critics of our term; neither shall we quarrel with any one challenging our conception and interpretation of the early manifestations of this form of heart disease. If this paper does nothing more than to again direct attention to the earliest signs of cardiovascular break-down, as it is seen by all of us among our middle-aged patients and colleagues, it will have more than fulfilled its mission."

The meeting was adjourned at 11 p. m.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular monthly meeting of the Camden County Medical Society was held in the Camden City Dispensary Building, March 7, at 9 p. m., with President A. B. Davis in the chair.

Dr. T. K. Lewis, Chairman of the Committee on Medical Economics, reported the Committee as functioning and gathering data.

Dr. Hyman I. Goldstein brought up for discussion Assembly Bill 170, to wit: A bill that would supplement the Chiropody Act. It proposes, in effect, to define chiropody as "the examination, diagnosis or treatment of any ailment of the human foot, by surgical, medical, mechanical, electrical or physical means". He moved that this Society record its opposition to this Bill, and his motion was seconded by Dr. T. K. Lewis, and discussed by Drs. A. H. Lippincott, A. Macalister and E. B. Rogers. The motion was carried that this Society oppose the passage of Assembly Bill 170 and so notify our Assemblymen.

Dr. William G. Shemeley, Jr., was elected to membership.

The Scientific Program consisted of a Symposium on Thyroid Disease, the papers being presented by: Drs. C. H. Jackson, "Causes of Thyroid Disease"; T. M. Kain, "Medical Care of Thyroid Disease"; I. E. Deibert, "Surgical Care of Thyroid Disease"; and J. E. Roberts, "X-ray Therapy".

Formal discussion was opened by Drs. Goldstein, Ciliberti, Lippincott, Davis, Hollinshed, Jack, Shafer and Deibert.

There were 49 members and 2 guests, Drs. Diverty and Hollinshed, from Gloucester County, present.

Fourth Councilor District Meeting

This District Meeting was held in the Camden Club, 315 Cooper Street, Camden, on the evening of April 4, with the Camden County Medical Society acting as host to the members from other Counties. The program was opened by a Dinner, at the Club, with the Councilor, Dr. James A. Fisher, of Asbury Park, as Toastmaster. At the conclusion of the dinner, the Guest Speaker, Dr. Seth Brumm, of Philadelphia, delivered an Address entitled "What of the Doctor's Economic Future", of which the following is an abstract:

"Just as bacteria in the agglutination tests gather together, presumably for defensive action against a common enemy, so do the factors operative in the field of medical economics array themselves for a formal joust, despite our willingness or unwillingness to admit the possibility of impending conflict. It is not sufficient to sound a loud blast 'to arms' but rather is it the part of good strategy to look carefully into our opponent's prospective line of attack and thus enable ourselves to prepare properly to meet it. It would be foolhardy for any person or persons to assume the responsibility of such a campaign inadequately prepared. It is our purpose to bring forward for consideration features of the situation that confront the public and the medical profession, in the matters referred to in the Reports of the Committee on the Costs of Medical Care.

Medical economics at present is an all-absorbing topic. Interest in it at this time has been brought about by the Final Report of the Committee on the Costs of Medical Care, and more especially by the *recommendations* of the Majority Report. In view of the factors dominating the activities of this Committee and the limitations of their fields of study, we cannot escape the conviction that the thought of *socialization of medicine* was seriously entertained from the very beginning and only those features of the situation that lent themselves to the confirmation of this thought were given adequate consideration.

Socialized medicine is essentially a European conception, which first saw the light of day in Germany. After the Franco-Prussian War, when the German Empire was yet in swaddling clothes, the peasants and workers, fully alive to their class distinctions and limitations, turned their various local social organizations into beneficial health and mutual insurance enterprises. Aided by the passage of friendly laws these expanded. The law of 1876 called for the registry of these free assistance funds (Freie Hilfskassen), but in 1881 Emperor William I, instigated by Chancellor von Bismarck, announced a policy of compulsory insurance against sickness, accident and incapacity of all workers in industrial pursuits which was formally crystallized in the law passed June 15, 1883. It was the sop given to the church and the people to quiet their disapproval and resentment of the extension of the Prussian idea of universal compulsory military service to the German Empire. Other possible concessions might have involved interests more troublesome to manipulate. Handling or mishandling the doctor-group has always been relatively easy. * * *

England, receptive to continental ideas, accepted the idea born in Germany which is known as the panel system and today stands almost bleeding

and pathetic from the so-called dole system which embraces the panel medical system and a host of other socialistic schemes, as the result of which the income of the doctor is not only about $2200 per year, but his opportunities for enlarging this from independent practice are reduced to zero, since nearly everyone in his field is partaking of some kind of a dole, and therefore is eligible for the benefits of the panel. * * *

It has been said that English physicians are today satisfied with their system of State Medicine. Don't you believe it. I tell you it is not true. No matter who tells you that the people and the doctors in England are now satisfied with the panel system, I tell you it is a false statement; it is the most fallacious utterance imaginable. * * *

The children of Israel during the exodus bled and died rather than exist under the humiliating servitude of the Pharaohs, and we can take inspiration from their trials and vicissitudes in our endeavor to sustain the independent and respected position of our American profession. True, a life boat is naturally acceptable when one is on a sinking liner, but who among us would assume by election an ocean voyage in such a craft? Therefore, to say that these emergency medical substitutes are ideal, and are to be sought after, is beyond all sense of reasoning and logic. Unfortunately, these European influences have already projected themselves into this country, only they are traveling under other synonyms. For instance, we have paid voluntary group practice, we have compensation boards, we have contract practice, we have diagnostic clinics, we have dispensary abuse, industrial medicine, etc., many of which now function on a purely voluntary basis, but once any of these schemes becomes inscribed upon the statutes of our various states, the labor necessary to bring about a referendum necessary for their repeal or their modification would be so comprehensive that such changes would never come to pass. Our experience with the Workmen's Compensation Act should convince us of the truth of this statement.

For your information, I might tell you, gentlemen, that medical care per family per year costs in America $150—of which $37 is spent for patent medicines and drugs—the balance includes hospitalization, nursing, dentistry, and the physician's services, but the physician receives but $20 from this amount; while, on the other hand, the American family pays per year $674 for pure luxuries, many of which from a medical standpoint are detrimental to the public's health and could be dispensed with. In other words, the public appears to be very happy to spend $674 for pleasure but reluctant to spend $150 for medical care. It is argued that the medical drain on the financial resources is not so evenly distributed as these figures would tend to show, but that it accumulates in selective family groups and assumes confiscatory proportions. Granting this to be true—there are still mighty few individual families whose medical bill approaches the average of the luxury bill quoted.

Cosmetics present an engaging picture. According to the *Philadelphia Record,* Sunday, January 22, 1933, Philadelphia women alone spend yearly $18,529,700 on cosmetics—an average of $25 for every female over 15 years of age. The nation's bill in this field approaches $375,000,000.

Medicine, as an industry, which simply means money turnover, and not the interest on the $3,000,000,000 invested in buildings, etc., amounts annually in the United States to $5,200,000,000. In other words, the industry of medicine is the fifth largest in the United States and the third largest in the city of Philadelphia; from which it may be readily seen why insurance companies and large industrial and political parties are after this business. In fact, the various activities outside of the physician, himself, have taken all of the medical dollar but 29.9 cents already, and with this 29.9 cents more than 80% of the medical practice is conducted. This information is contained in the report of the Committee on the Costs of Medical Care. It is necessary for me to point out, however, that while there is a tremendous turnover in the money figures quoted, we are taking care of 120,000,000 people and that there are about 140,000 physicians living off that amount. In other words—there is a large volume of business with small returns.

So, let me impress upon you the fact that it is ridiculous when you hear talk about the white-collared individual not being able to pay an average of $20 per year for doctors' services, when your morning, afternoon, and evening papers cost you about the same amount of money. The latest flash from the Committee on Costs of Medical Care subsequent to its full report informs us that 1 out of 10 people cannot pay at all for medical care. Another equally reliable source gives us the desolating news that only 1 out of ever 5 can own automobiles.

The American people must learn to budget the item medicine. How they do this is no concern to us. If they wish to carry some form of health insurance or some fund equivalent to the Christmas Fund, or save in the old proverbial sock, it is a matter of their concern, but the fact is dominant that the doctor is sick and tired of giving $630,000,000 annually for free medical care in this country, and deeply aroused to the possibility of the further engrafting upon him the socialistic schemes previously referred to. In the city of Philadelphia alone we give annually $20,000,000 free medical service. In a study of the nation-wide significance undertaken by one of the well-known foundations it has been shown that in 1900 there were but 175 clinics in this country. Today there are 8000. The population increase from 1920 to 1930 was 1.3. This was not only the most prosperous 10 years in the history of the country but the healthiest, yet organized medical service in clinics increased from 3944 in 1921 to more than 7000 in 1931, and most of this service was rendered either gratuitously or for a nominal fee sufficient for the payment of the incidental clerical work. It is, therefore, very evident that this increase in free medicine was not due to population increase, the demands of increasing and pauperizing illnesses, nor of financial distress on the part of the public; but rather to the zeal and enterprise of outside busybodies, welfare agencies, and a host of modern sociologic enterprises.

Of course, the question of taking care of the poor is one in which we are all vitally interested. There is not a doctor in the United States who does not feel that the indigent should be taken care of free of charge and well taken care of, but thinks that the economic responsibility of this load should not fall upon the physician, but is purely and justly a civic or community liability. The problem is not up to the doctor but is up to the towns, cities and states to look after this responsibility. The doctor should not be asked to give his wares free of charge any more than the wheat grower of the west should be asked to deliver free wheat. We, therefore, oppose any form of contract practice, paid diagnostic clinics, dispensary abuse, medical control by compensation boards or any procedure that deprives the physician of his independence in the distribution of his commodity,

namely medical service. It is only just that any doctor working in the so-called free dispensary should be duly compensated, the same as any other of the personnel of that institution. The *doctor* should be at least as important to the care of the sick as the *superintendent*, and it is more than essential that we reëstablish the doctor in his rightful position in the community."

This was followed by a "Clinical Program" provided by the Staff of Cooper Hospital.

CAPE MAY COUNTY

Eugene Way, M.D., Reporter

A meeting of the Cape May County Medical Society was held March 14 at 8.45 p. m., at the Atlantic Shores Hospital, Somers Point, with 24 members and guests present.

Professor Earl B. Craig, of Philadelphia, gave an illustrated lecture on "Treatment of Operative Uterine Carcinoma with Use of Radium", which was extremely interesting and up-to-date. It was discussed by Drs. White, Townsend and Corson. Dr. Craig was voted the thanks of the Society.

Dr. Henry O. Reik gave an address on "Review of Medical Economics" with a digest of some recent publications concerning *State Medicine.* Dr. Reik, who is always pleasing, eloquent and entertaining, was at his best and held his audience spell-bound for nearly an hour, which seemed but a few minutes. He was the complete master of his subject, citing conditions in this country, England and other countries, and fully explaining what to many of us had seemed a complicated affair. We hope Dr. Reik's address will be published in full. He was voted the thanks of the Society.

Our genial host, Dr. White, Superintendent of the Hospital, was also voted the thank of the Society.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The April meeting of the Society was held with all its members guests of the Vineland Training School. The Society has long appreciated the generous hospitality of the Vineland Institutions. The heads of the various departments escorted the guests through the buildings and over the grounds. The Institution has grown from 1 cottage with 3 children to 400 children and many fine buildings, with several hundred acres of land and a colony for adult inmates. Various grades of mental and physical impairment are treated with the latest methods of physiotherapy and psychotherapy. The meeting was held in the beautiful and spacious auditorium, and the large number of physicians from Cape May, Atlantic, Gloucester and Salem Counties were treated with a musical entertainment by the School Band.

In the absence of President J. H. Winslow, Dr. H. G. Miller presided. A good balance was reported by Dr. H. H. Wilson, the Treasurer. Dr. L. E. Myatt reported for the University Course of lectures to be held in the Nurses' Home of the Bridgeton Hospital. Dr. E. S. Corson reported for the Public Health and Legislation Committee on the prosecution and conviction of chiropractors and naturopaths. Sentence was suspended 3 months, to May 3. The Judge proposed that the medical profession clean up its own ranks as well as those of the cultists. He referred to the frequency of criminal abortions. Strong efforts are being made to bring the guilty ones to the bar of justice and to stop the practice. Dr. Reba Lloyd invited the Adjoining County Societies to meet at her County Sanatorium, Ivy Manor, for the July meeting.

Drs. Carl N. Ware, of Shiloh, and Anthony Pino, of Bridgeton, were elected to membership. Prof. Johnstone, head of the Institution, welcomed the Society and spoke of the present more open relations that existed between all institutions and the public than formerly. Public inspections are now solicited at any time. A Medical Staff has been maintained since the foundation, with specialists as consultants. The psychologic study of the child has been undertaken in order to determine his capabilities and apply the indicated correction.

A "summer school" for teachers is patronized by persons from all over the United States to consider what the feebleminded are like. The special class idea laboratory rather than custodial is emphasized. Only sufficient numbers for study are desired.

Dr. P. Brooke Bland discussed "Injuries to the Infant During Delivery". (Paper to be published in the Journal later.)

Dr. Edgar A. Doll, of the Training School, lectured on the "Mental and Motor Developments of Birth-Injured Children". Complete survey of the children has been made to determine the cause of mental and motor deficiency: ⅔ of the mental deficiency is due to heredity; ⅓ not systematized. Birth injuries account for more than mental deficiency. Three motor cases and 3 mental cases were presented, physical therapy had been applied for 5 years. The difference between athetosis and spasticity was demonstrated and discussed.

There was 1 patient showing a combination of both types. A series of motion pictures illustrated the methods of training, treatments, and improvements.

Dr. J. T. Rugh opened the discussion and reviewed the various operative methods that had been used to restore function, and he concluded that the tenotomy method, with restraint and physiotherapy, presented the best results. Dr. Bland discussed a case of dislocation of right shoulder, and said this is one of the most difficult conditions to treat. The only method that had been successful was elevation of the arm at right angle to the body and flexed on a right-angle splint and kept in place for one year, with massage at stated times. Early recognition and treatment are the "sine qua non" to success in all deformities due to birth traumatism.

ESSEX COUNTY

Earl LeRoy Wood, M.D., Reporter

March Meeting

The President, Dr. William H. Areson, presided at the meeting of the Essex County Medical Society March 23, with the largest attendance we have known for a long time. There was a double attraction in the topic—"Legal Problems Connected with the Practice of Medicine"—and the call to vote on the "Registration of Specialists".

Murray Jenkins, A.B., L.L.B., on the legal topic, made an address which, combined with his answers to questions by the audience, made the meeting most helpful in bringing clearly to mind many important points in law which vitally concern a practitioner of medicine; e.g., (1) things a doctor should never do—such as being misled on the witness stand into giving expert testimony when his duty ends with giving testimony on fact only; (2) things a doctor must do—such as making record, at the time, of what he tells or advises a patient. Depend on written specific permit for operation, not too

much on a stereotyped printed form. The members were free in asking questions, general or on specific experiences, and Mr. Jenkins' answers were clear, concise, and illuminating on any law concerned.

On the Registration of Specialists, the resolution presented was, that: "The Essex County Medical Society does *not* approve the formation of the county committee to accredit specialists in this county." This was unanimously carried by vigorous "*ayes*". For the negative, not a "*no*" was heard.

The following *Resolution* was moved by Dr. Danzis and, by vote, was unanimously adopted:

Whereas, it has come to our attention through authentic sources of our American press of repeated and deliberate physical maltreatment and various indignities perpetrated upon a certain group of our professional colleagues in Germany because of their racial origin or religious faith by an organized political group, and

Whereas, it is a well-known fact that some of those against whom these injustices have been committed are men of high esteem, having contributed largely to the advancement of modern medicine for the benefit of mankind, and

Whereas, it is also a well-known fact that all through the history of modern progressive medicine beginning with the last century until the present day, we find in the medical roster such men as Cohnheim and Traube, both pioneers in experimental histology and pathology; Henoch, the pediatrician (of purpura hemorrhagica); Neisser, Paul Ehrlich, Wassermann and Henle, famous anatomists and histologists; Unna, the dermatologist; M. H. Romberg, the neurologist; Landsteiner, the immunologist (Nobel Prize 1930); Erdheim, the pathologist; Schick of the famous Schick test; Israel and Zuckerkandel, both famous as surgeons and anatomists; Hajek and Von Neuman, famous nose and throat specialists; Politzer, the world's most famous ear specialist; Winterberg, the cardiologist; Boas, the gastro-enterologist; and Zondek, the clinician and research worker; all of whom are members of the very same race against whom this campaign of hate and discrimination is at present promulgated and at times violently carried out; therefore, be it

Resolved that we, the members of the Essex County Medical Society, at a regular meeting assembled March 23, 1933, in the name of fair play and ordinary human decency, strongly protest against and voice our condemnation of such outrageous and inhuman practices perpetuated against this defenseless group of members of our profession, and we appeal to all the fair-minded people who have the interest of humanity at heart to join us whole-heartedly in this protest.

April Meeting

The Essex County Medical Society met Thursday evening, April 13, at the Academy of Medicine of Northern New Jersey.

Dr. Harry H. Satchwell, Chairman, reporting for the Educational Committee, said he would not recommend that Essex County sever its post-graduate educational activities from those of the State Society, nor would he recommend that the State Society Committee detach itself from Rutgers University. Coöperation of the Extension Division of Rutgers University is valuable in many ways, facilitating the securing of lecturers from other universities because of contact through the Inter-University Extension Conference. The prestige of the courses is raised, and "bigger" men give better lectures and are more prompt in their attendance, thus increasing the general success. The fees charged will be decreased to $10 next year and any profit accruing from the Courses given in any County will revert to that County; while, on the other hand, the University guarantees against loss. Dr. Satchwell felt that the *quality of the courses* is better through the University association and recommended its continuance.

Dr. Satchwell received hearty commendation for his part in this work.

Dr. Elbert S. Sherman reported that the Welfare Committee has successfully opposed certain bad Bills in the legislature; and, that the Bills advocated are progressing satisfactorily.

The Essex County Society went on record as opposing any change in the Medical Practice Act that might allow greater privileges to men holding limited licenses, such as osteopaths and chiropractors.

The Nominating Committee recommended the following named additional Delegates and Alternates to the State Society, and they were unanimously elected.

Delegates: Richard N. Connolly, William H. Areson, Henry J. F. Wallhauser and James H. Lowrey.

Alternates: A. Russell Sherman, Charles G. Crane, Kenneth Blanchard, Harry H. Satchwell, Harry Schreck and John E. Toye.

The motion was passed that—*the Essex County Society advocated and instructed its representatives to secure a 25% reduction in the expense of the office of the Executive Secretary of the State Society.* The general meeting adjourned and a meeting of the Delegates was held.

Dr. William H. Areson was elected President of the Delegates, and Alfred Stahl, Secretary.

The name of Dr. Francis R. Haussling was endorsed as a candidate for the office of Third Vice-President of the Medical Society of New Jersey. The representatives of the County were instructed to secure this nomination.

April Meeting of Delegates

The second meeting of the Essex County Delegates held Friday evening, April 21, 1933, at the Academy of Medicine, Newark, was well attended. The Chairman of the Delegation, Dr. William H. Areson, presided and the Secretary, Dr. Alfred Stahl, performed the functions of his office.

Plans and policies for the meeting of the House of Delegates on June 6 were discussed and appropriate actions taken. *The candidacy of Dr. Francis R. Haussling for the position of Third Vice-President of the Medical Society of New Jersey was enthusiastically discussed.* Delegates reported that since the news had spread that the Essex County Medical Society favored the candidacy of Dr. Haussling he was strongly endorsed by all who heard of it.

The Delegation went on record as favoring the reëlection of Dr. Wells P. Eagleton as a member of the Committee on Finance and Budget, and the reëlection of Dr. Henry C. Barkhorn as Chairman of the Publication Committee.

On March 23, 1933, the following new members were elected.

Regular Members: Drs. Raymond J. Brady, F. P. Carrigan, Harry B. Harris, John J. Mohrbacher and William P. B. Nemzik.

Associate Members: Drs. Otto Brandman, Theodore Loch Dulany, David M. Levinson, Louis Pilloni and Albert Sasso.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The Twenty-second Anniversary of the Academy of Medicine of Northern New Jersey was celebrated on March 16, 1933. The guest of the evening, Prof. William S. Carpenter, of Princeton University, gave a very interesting and detailed account of the "Medical Aspects of the Princeton Survey". Following this paper, which was immensely enjoyed by the members and guests of the Academy, Professor Carpenter answered the questions of the various members.

Dr. William Gauch, Chairman of the Nominating Committee, gave the following report: President, A. W. Bingham; Vice-President, M. Danzis; Secretary, Adrian Ralph Kristeller; Treasurer, Henry C. Barkhorn; Corresponding Secretary, Harvey T. Herold; each for a period of 2 years. Board of Trustees, Wells P. Eagleton and Edward J. Ill, each for 5 years. Committee on Admissions, Donald Miner; and Committee on Library, Frederick Alling; each for 3 years. The report was accepted.

A collation was served following the meeting.

Eye, Ear, Nose and Throat Section Academy of Medicine of Northern New Jersey

A. Russell Sherman, M.D., Secretary

March Meeting

The March meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, March 13.

Dr. Lee W. Hughes, of the Nominating Committee, announced the following nominations for Officers for the coming year: Chairman, Dr. Browne Morgan; Vice-Chairman, Dr. J. L. Courrier; Secretary, Dr. A. Russell Sherman.

Dr. Hughes described a patient with a pituitary adenoma, the second he had seen in a rather short time. In reply to questions by Drs. Moore and Failing, he stated that there had been present in both cases a marked increase in weight, but no papilledema.

Dr. Rados pointed out that absence of papilledema was the rule in these cases, and called attention to the fact that x-ray treatment has been found very effective.

Dr. Russell Sherman described a patient seen recently in Dr. Curtis' clinic, who developed bilateral cataracts after having had tetany following thyroidectomy.

Dr. Berta Drapkin read a paper entitled "The Significance of Slit-Lamp Microscopy", in which, after mentioning briefly the development of that instrument, she discussed many conditions clinically demonstrable with the slit-lamp, but, which cannot be seen by any other method of examination.

April Meeting

A clinical meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held in the Out-Patient Department of Newark Beth-Israel Hospital, Wednesday, April 19, at 8.30 p. m., and included the demonstration of patients in the clinic rooms. At the business meeting the Chairman, Dr. E. A. Curtis, presented the list of nominees for Chairman, Vice-Chairman and Secretary for the coming year. These were: Dr. Browne W. Morgan, Chairman; Dr. J. L. Courrier, Vice-Chairman; Dr. A. Russell Sherman, Secretary; all were elected unanimously.

Dr. A. Mamlet described a patient who, with repeated positive blood cultures following a simple mastoidectomy, made an uneventful recovery and who was clinically symptom-free during the time those positive cultures were being obtained.

Dr. H. Z. Goldstein described a patient who presented clinically the picture of a lateral sinus thrombosis with abscess formation in the scalp behind the ear. Two weeks previously he had some abdominal pains, but they had disappeared, and at the time of sinus thrombosis development the abdomen was negative. The patient died shortly after performance of the operation, and autopsy disclosed a walled-off, ruptured appendix with a large abscess of the liver; and the lateral sinus thrombosis was considered to have been metastatic.

Dr. Danzis cited a case illustrating an extension of infection from the abdomen to the head. In this instance, 48 hr. after a blow by a baseball, the patient showed signs of peritonitis, the cause of which was not disclosed by a laparotomy. The patient died, having shown signs of meningeal irritation, including increased spinal fluid pressure, and at autopsy he was found to have had an encephalitis.

Dr. M. Weinberg presented 2 patients: (1) A child who had a lateral sinus thrombosis without involvement of the mastoid; the infection having, apparently, extended from an acutely inflamed middle ear by way of a thrombotic emissary vein; (2) a man who had developed an acute edema of the larynx, of unknown origin, necessitating emergency tracheotomy.

Dr. Milton Friedman gave a short talk, illustrated with lantern slides, concerning treatment of carcinoma of the antrum, larynx, tongue, lip and alveolar ridge by massive doses of x-rays and radium.

Patients on the eye service were demonstrated by Drs. Rados, Drapkin, Schulsinger, Shapiro, Zimmerman and Daron.

The following conditions were shown: lenticonus posterior; albinism in negroes; recurring sympathetic ophthalmia; congenital paralysis of the external rectus muscle; ectropion of the uvea; disc-shaped macular degeneration; coloboma of the macula; coloboma of the optic nerve; high degree myopia in children; retinitis proliferans following a neuritis occurring in the eye of a patient under antiluetic treatment with arsphenamine.

Dr. Rados showed lantern slides of several photomicrographs made from sections of conjunctiva in cases of Parinaud's conjunctivitis.

The meeting adjourned at 11 p. m., and was followed by refreshments.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

March Meeting

Dr. Ralph M. Tyson, Professor of Pediatrics in the School of Medicine, Temple University, addressed members of the Gloucester County Medical Society on March 16 at the Oakwood Country Club.

Dr. H. W. Wright, of Williamstown, was elected as a new member.

A report of the Committee on Medical Care was presented by Dr. W. J. Burkett, and copies were ordered mimeographed and sent to each member.

The Society adopted the A. M. A. physicians' automobile emblem, on which is inscribed "The Gloucester County Medical Society".

An invitation was received to attend a meeting to be held at Jeanes Hospital on March 21, to hear an address by Dr. Joseph Colt Bloodgood.

Drs. H. Garrett Miller, of Millville; Herschel Pettit, of Ocean City, and E. M. Richardson, Camden, who were visiting Delegates, gave short talks. Drs. Kinney, of Camden, and Crowe, of Ocean City, were also visitors.

Following the meeting, the members of the Auxiliary joined the doctors at a supper.

Those present were: Drs. William Pedrick and Charles Pedrick, Glassboro; Ralph Hollinshed and Edward Ristine, Westville; H. B. Diverty, Duncan Campbell, William Brewer, J. Harris Underwood, Ralph Moore, E. E. Downs, Paul M. Pegau, W. E. Crain and Fuller G. Sherman, of Woodbury; Oran Wood and H. L. Sinexon, Paulsboro; C. I. Ulmer and T. M. Gardner, Gibbstown; F. G. Wandell, Clayton; Don Weems, Wenonah; Victor I. Barrows and W. J. Burkett, Pitman; I. J. Stewart and B. A. Livengood, Swedesboro, and Horace M. Fooder, Williamstown.

April Meeting

The Gloucester County Medical Society heard interesting talks at a meeting held April 20 at the Oakwood Country Club. Dr. Robert A. Kilduffe, Atlantic City, addressed the Society on laboratory work and Various Kidney Diseases, while Dr. Edward Weiss, Philadelphia, illustrated his talk on "Modern Conceptions of Kidney Diseases" with lantern slides.

Drs. Burkett, Fooder, Hollinshed, Underwood and Ulmer, comprising a Committee to Investigate a National Report on Medical Costs, made its report and following the meeting a luncheon was served, with members of the Society Auxiliary in attendance.

Members attending included: Drs. William Pedrick, Hollinshed, Sinexson, Ristine, Burkett, Underwood, Black, Pegau, Bowersox, Wright, Weems, Stout, Royers, Wood, Crain, Knight, Moore, Livengood, Campbell, Diverty and Nelson.

HUDSON COUNTY

Charles Sirken, M.D., Reporter

March Meeting

The regular meeting of the Hudson County Medical Society was called to order by Dr. Pyle at 9.05 p. m. on March 7. Drs. Pollak and Quigley reported assurance from the Hudson County State Senator of his opposition to S. 126 and of similar majority sentiment in Trenton.

The report of the Antidiphtheria Campaign Committee follows:

(1) The Antidiphtheria Campaign Committee should be a permanent organization working in conjunction with the Public Health Committee of Hudson County Medical Society.

(2) The Vaughn Plan of Procedure is to be followed in so far that all children to be immunized shall be referred to a general practitioner; none to be done in clinics, public schools or public buildings.

(3) The charge shall be a nominal fee, and nothing to indigents except during regular office hours. Definite days and hours to be designated by the individual practitioner.

(4) In preventive medicine, each physician shall be a subsidiary member of the local Board of Health.

(5) The city to be divided into districts and the physician in any district to administer the inoculation of children of that district.

(6) The local Board of Health to supply the toxin-antitoxin.

(7) The publicity of this campaign to be carried on by letter, through the public schools and under supervision of the Medical Director. Women's Clubs, Parent-Teacher Associations, the Tuberculosis League, Red Cross, Exchange Club, Parochial Schools, Lions, Kiwanis, Rotary, Elks, Knights of Columbus, Zontas and Masonic Clubs are requested to aid in the publicity part of the campaign.

(8) The local Board of Health will inform every mother who has an infant aged 6 months or more, to have it inoculated against diphtheria to secure immunization of every child of the pre-school age.

(9) Records are to be kept in duplicate. One to the local Board of Health and the other to the Board of Education.

(Signed) J. L. Rosenstein, Chairman

Dr. Jaffin, being granted the floor, made the following remarks: Back in 1859 or '60, there was born in Columbus, Wisconsin, the *great Dane,* who is with us tonight. His father was a minister of the gospel in this State who was sent West as a missionary. Unlike his brethren, he chose *medicine* rather than *the cloth,* and found his way back East where on the 14th of March, 1883, this Dane received his (M.D.) degree.

Since then, this gentleman has graced our neighboring City of Hoboken with his genial personality and has won the admiration, affection, and confidence of the public and the profession. In spite of a busy practice, he found time for many broad activities. Early in life he was associated with that famous surgeon of the old German Hospital, in New York, Dr. Fred Langer. Later, he traveled extensively abroad, studying continental medicine and foreign languages, especially German and Italian; published articles on these travels; published some research on the historic evidence of the origin of syphilis; was active with the Commission on Cancer Control, Mosquito Extermination, and, during the war, served as contract surgeon at Stevens Institute. Not only is he a Trustee of this Society, but serves very actively as such in the Society for the Relief of Widows and Orphans of Medical Men in New Jersey.

It has been the privilege of many of our older members to have known this charming gentleman. For the benefit of those who have been less fortunate, and for the younger members especially, I beg to introduce the following resolutions in his honor:

Resolutions of the Golden Anniversary of Dr. Rosecrans' Practice of Medicine

Whereas, it is given to but few members of our profession to complete a half-century in the practice of medicine, and

Whereas, our colleague and fellow member, Dr. James H. Rosecrans, will this month celebrate his 50 years in practice, and

Whereas, he has always stood out as a prominent example of the traditional physician, combining scientific, cultural and communal interests;

Be it, therefore, resolved, that we, the members of the Hudson County Medical Society, extend to him and his family our congratulations and felicitations on this happy occasion.

Dr. Spence's suggestion that Dr. Rosecrans be the Guest of Honor at the Annual Dinner was accepted.

The Nominating Committee submitted the names in nomination for the elective officers to serve during the ensuing year, and recommended that a special election be held in May.

Dr. Klaus announced that the Annual Dinner will be held on Saturday evening, April 22, at 8 p. m., at the Masonic Club, Jersey City; that it would be a *beef-steak dinner;* and that tickets would be $3 each.

Based on Dr. Lange's report for the Committee on Post-Graduate Education, Dr. Pollak moved that we proceed with plans to take the outlined Course, and endeavor to secure 90 subscribers at $5 each. This was seconded and carried.

Having taken the usual course, the following applications received the second reading, preliminary

to being voted into membership in the Society: Drs. Hyman Frieman, Raymond S. Driscoll, Harry Feinberg, Louis J. Garibaldi, Irving I. Lynn, and William J. Mulvihill.

The Secretary, being so instructed, cast one ballot for the election of all these applicants.

Dr. William L. Yeaton, of Hoboken, former Secretary of the Society, had, it was reported, just suffered an irretrievable loss in the death of his wife, fatally injured by falling from a horse.

The Scientific Session was opened by a talk on "The Economics of Socialized Medicine" by Dr. Iago Galdston, in part as follows:

Why is there such a strong movement for the socialization of medicine? There is, undeniably, a great need among our people for additional and more extensive, medical service of both prophylactic and curative nature. The annual sickness bill of this nation runs into millions of dollars. It is estimated that at least 40% of American mortality is preventable or postponable. It is said that there are constantly 3,000,000 people ill in this country, and that some 50% of this illness is probably preventable. The other factor is the deep-rooted conviction that by reasonable application of the available resources of medical science, the average lifetime could be extended, much illness could be avoided, and much of the economic loss saved.

The answer to this question—"Why do not larger numbers of our citizenry receive adequate medical care"—is, simply, that the *present-day medical service is too costly;* in the sense that the commodity is beyond the means of the contemplative purchaser. The average American family cannot afford to purchase adequate medical care, possibly, because 65% of the people in the United States own but 15% of the wealth of these States; while the remaining 35% own 85% of the national wealth, and, in this group, 2% of them own 40% of the total wealth of the country. According to the National Bureau of Economic Research, 66.7% of our income-receiving individuals have an annual income of between $500 and $1500. An additional 23.9% have annual incomes of between $1500 and $2000. In other words, 90.6% of the people receive but 58.7% of the total income, in contrast with 9% of the people receiving, roughly, 40% of the annual national income. These figures reveal why adequate medical care is too costly for the vast majority of people, and also, partly why there is so much preventable illness and avoidable loss of life. Our capitalistic system is aiming to overcome this objectionable condition through subjection of the medical profession to a scheme of mass production in medicine. Dr. Frederick Hoffman remarks that: "In countries with low standards of labor and of living, with a government administered by an entrenched, autocratic, governing class, remote from the life and labor of the wage-earning element, the compulsory insurance principle is quite likely to appeal as a panacea, or a solution, even though, as in Germany, it proved merely the means of postponing the inevitable disaster for a generation or so." Dr. Hoffman so viewed the matter in 1919. Since then, the dire and inevitable economic disaster which he foresaw for Germany, has engulfed the entire civilized world, including the United States. The experience of the human race during the past 20 years mocks the vain confidence of all the glib-tongued politicians and statesmen, because social insurance, in a world motivated by the money-making incentive, is a pious fraud. And Prof. Taussig deflates the fraud by pointing out that the compulsory insurance charges will ultimately come out of the working man's own earnings.

In the inequitable distribution of national income lies the economic root of the whole evil, but we fail to recognize it and, like so many quacks, instead of striking at the underlying pathology, we plaster our patient with superficial salves to cover his festering sores. Our people are not able to buy the essentially necessary amounts of medical service, for the same reason that they are not able to buy back the major portion of their own produce, be it food, clothing, shelter, or what. The problem which the medical profession faces today, and which society as a whole faces with regard to medicine, is part and parcel of the larger economic and social problem which enmeshes all mankind. There is little hope that an effective solution of the medical problem will be achieved until the under-lying economic factors are set aright. The argument of waste in the individualistic practice of medicine, as an item of costliness, represents a puerile attempt to solve the problem by any other but the fundamental procedure.

If we could achieve socialization in the distribution of income, there would be no need for socialization of medicine. But, of course, while this solution is theoretically possible, it is highly improbable that any such readjustment in the distribution of national income will take place so long as the current economic system prevails. If more medical service is to be secured for our people, for the same collective sum, this can be accomplished, under existing circumstances, only by lowering the price of the service. The costs of medical care can be lowered by introducing into medical practice the methods of mass production and of chain store distribution. And this is the stark, naked, economic motivation of socialized medicine.

It will avail us little to attempt to reverse the trend of events. We must realize that we are but a paltry 150,000 men in a social economy that embraces 140,000,000 persons. The people in the United States need more and better care. If that care can be procured only at the expense of the medical profession, it will be so procured; whether we like it or not. If we persist in dogged opposition, the socialization of medicine will take place, nevertheless, and with little, if any, consideration being given to safeguarding our professional and individual interests. If, on the other hand, we are acute realists, and, appreciating the inevitable, make a coöperative contribution to the solution of these medical problems, we shall not only win the good will of the nation, but we will also be in a position to *modify* and affect the form of socialization which medicine is to undergo. What has our opposition availed us? What could it avail us, the economic reality being what it is? Can we not learn from our experience that with but very few exceptions the socialization of medicine has gone on, at times despite and at times because of, our opposition?

There is still time, however, in which an enlightened medical leadership may take hold of the helm and set the course of progress. Let us formulate some workable plans: to eliminate waste; to render too costly services less burdensome; to make more and better medical service available to a larger proportion of our people. Unfortunately, however, time is not ripe, nor are our considerations sufficiently mature, to make possible the formulation of a finished, rounded-out, suitable and workable plan.

Before we may hope to prove effective in dealing with any of the major medical problems which face us, we need a coördinated and well-disciplined medical profession. At the present time, there are still too many physicians outside the fold. We witnessed in New York City, some time ago, a pathetic and ludicrous spectacle. The major staff of a city hospital was arbitrarily dismissed by a politically appointed commissioner. The County Medical Society entered a vigorous but totally un-

availing protest, for on the morrow the positions were filled by other doctors, members of the very protesting County Medical Society. Recently, in one of the Counties of the State of New Jersey, a medical society met to consider replying to the attacks of a politician who charged the medical profession with being primarily and exclusively interested in the "almighty dollar". The meeting, it is alleged, was packed with doctors holding city jobs and political appointments. These politically dependent doctors voted down the proposed motion of censure and thus succeeded in eviscerating their own medical organization.

County medical societies must urge their members to study and devote themselves to the economic and social position of the profession as well as to scientific matters. The situation calls for an increase of dues, and for the accumulation of what might be properly called a "war chest". The medical profession also needs shock troops—men and women who are trained and competent to present to the public the profession's side of whatever controversies and problems we may be called on to face. We need to interpret medicine to the public in order to secure the public's sympathy, understanding and support.

Constructive Suggestions for a Medical Program

Dr. Nathan B. Van Etten,
New York City

Some 23,210 physicians have died in the past 5 years, and a few have retired; their places being taken by 27,370 new licenciates, brings the ratio of physicians to people up to 1 to 780, in the United States—an over-crowded profession. This is a higher ratio than that of any other civilized country; nearly 4 times the ratio of 1 to 2890 in Denmark, where every adequate medical service is said to be maintained. There should, therefore, be a definite program to limit the number of future graduates. Hospital beds have reached nearly a million in number, with 65% occupancy; yet more hospitals are being constructed and more projected.

Modern welfare-theorists are not satisfied to permit medicine to express itself, but, having debased the professions in several nations, they would spread their infection over all of the world. Has their time come; or shall scientific medicine decline their leadership and show the way? Who shall control medical service—the engineers—the racketeers—the Government—or the physicians? Shall we subscribe to the domination of great medical centers, as advocated by the "Majority Report"? Do we believe that these great masses of masonry will house generous hospitality and a spirit of helpful coöperation with the medical profession of their vicinity, or will they destroy local practice by oppressive competition?

Will they be able to secure sufficient return for their luxurious accommodations to operate their big machines in financial security, or will they offer their facilities at figures so low that, lacking governmental or enormous paternalistic endowment, they will fall by their own weight? Will the spirit of engineering be able to incubate personal kindness, sympathy and individuality, in these great health factories?

Shall we continue to let the racketeer administer the Workmen's Compensation process, with its insidious leading-up-to complete, governmental, compulsory, health insurance? We shall never break their hold unless the great labor organizations can be made to see that the disabled workman, and industrialist, as well as the physician, are getting a raw deal.

The invasion into any phase of the private practice of medicine, as has been done in the extension of governmental hospital service to veterans suffering from non-service disability, or in the restricting of the physician in the use of his best judgment, in regard to the dosage of medicine, is intolerable and should be continuously opposed.

The New York State Health Department's authorization to pay private physicians for treating venereal disease, has produced results—some individuals having been paid as much as $300 during the past year.

Public, impersonal, clinic-group treatment, can not be ideal. Routine treatment is usually disinterested treatment. The physician's office is the better place for education as to personal care, and as to responsibility toward all contacts.

The "Minority Report" objects to all forms of corporate, group, or contract practice under lay domination, as operating a competitive business and commercializing medicine, through solicitation of patients and lowering the quality of medical care by employing physicians of inferior ability—and operating in restraint of opportunity against the other physicians of the community.

Groups composed of physicians only, are usually an aggregation of specialists, and they can hardly be used to lower the costs of medical care to the patient; and here, again, bigness is a liability, in the sense that men in the lower grades of the group lose their individuality, and in slack times may be thrown out into individual practice, to begin again, but with no patients and a loss of years of opportunity.

I, personally, believe in the feasibility of zoning a great city and serving these areas by small hospitals, limiting this operation to the people who live in the district, and also including all of the reputable physicians of the zone. I hold the personal belief that the *open hospital* offers a solution of many problems, of caring for many people whose incomes are too low to provide them with adequate medical care at home—permitting their own physicians to employ hospital facilities when they are needed, and without loss of the personal relationship of physician to patient.

At the Buffalo City Hospital, there is offered to the citizens of Buffalo an institution with 1100 beds, with free or part-pay or full-pay, according to the applicant's financial ability. It offers to every reputable physician in Buffalo the privilege of attending his own patients in the wards—medical surgical or obstetrical—and permits him to charge a fee for his services, providing the patient is on a full-pay basis. So, 12,000 patients are admitted annually, 3000 of whom are sent in by physicians, and 35% of them actually attended by those physicians with or without fee. Of the 1027 physicians in Buffalo, 35% or more exercise "courtesy privileges" in this hospital annually. Every patient, in clinic or ward, is examined by a "credit officer" as to ability to pay, as to relation to an outside physician within 5 years—relation to religious, welfare, or social organization—to employment or to a responsible relative or friend. Ownership of property or a bank account, bars one from free service.

Upon admission to a bed, the last attending private physician is notified and a tentative diagnosis sent him. On discharge this physician is also notified and a discharge diagnosis sent him.

The hospital operates 4 branch dispensaries in distant city districts. These are first-aid stations and refer patients to the hospital when necessary. This hospital serves the tax-payers, avoids competition with the medical profession, which it tries to help, and furnishes a concrete example of a broad principle of service to the poor with the potential inclusion of all qualified physicians.

The "Minority Report" favors development of constructive plans for medical care by County Societies. Dr. William H. Ross, a former President of the Medical Society of the State of New York is largely responsible for evolution of the plan in Suffolk County, L. I., where they have 6 Medical Centers in 6 Hospitals in the County accommodating the entire profession; since they are open-hospitals. Taxation provides for the indigent, which in this county at the present time is 14% of the volume of practice. Physicians are paid for all their work in accordance with a standard fee list set up by the County Society.

The family physician treats the indigents and is paid at the rate of $2 in the office, $3 in the home, and all other services are paid for according to a standard fee list. The cost of health service in this country was $16 per capita. There are no venereal clinics, but the Health Department pays every physician for treating his own indigent venereal patients.

The shifting of the costs of medical care from the sick individual to the tax-payer, seems to be the objective of the "Majority Report", with very little regard to the quality of medical care and very little regard for the physician who has always been the only double tax-payer concerned in the care of the sick, because in addition to his taxes he serves the sick poor free.

April Meeting

The regular meeting of the Hudson County Medical Society was held on April 4 at the Carteret Club, Jersey City.

The report of the Committee on Tuberculosis Education and Early Diagnosis of Unrecognized Cases was accepted.

The Board of Censors reported favorably on the applications of Drs. Peter F. Ghee, Francis Barone, G. Lisanti, Marshal Bergen and Michele Tomaiuoli, and they were duly elected into the Society membership.

Report of the local Welfare Committee was made by Dr. Pollak: "The County Society Welfare Committee was requested by the State Welfare Committee to interview the legislators from Hudson County and to ask for their opposition to A-214; for their approval of A-170; and, inasmuch as S-126 had been withdrawn and S-125 had been amended to include some of the objectionable provisions of S-126, we were likewise asked to oppose S-125. The Chairman consulted Mayor Hague, of Jersey City, and was assured that the Hudson County Delegates and Senator would abide by our requests."

Dr. Pyle explained that the Hudson County Medical Society is running its own Post-Graduate Course at a fee of $5.

Report of Insurance Committee, by Dr. Benjamin: "Recently, attention of the Hudson County Medical Society has been drawn to the fact that the *loss experience* of the Insurance Company carrying physicians' liability insurance has been so bad that we may be liable to an increased premium rate. We recommend, therefore, that an Insurance Committee be appointed to coöperate with the State Society Insurance Committee. It shall endorse for our members one Insurance Company so that we may obtain the advantages of low rates on account of large volume of business. Further, that the Committee shall choose a sub-agent of the endorsed Company who will act as a broker for the members of the Hudson County Medical Society, and who will at all times act in the interest of our members. That the County Committee shall coöperate with the State Committee in reviewing any local suit for malpractice when so requested by the State Committee. And further, that they shall be active in attempts to keep at a modest rate medical fees for testimony of one physician or group of physicians in the interest of another physician. It was then regularly moved and carried 'that a Committee of 3, to be designated The Insurance Committee be appointed to serve for 3 years, the duty of the Committee to be the consideration of all matters pertaining to professional liability insurance, particularly the recommendation of an Insurance Company for all County Society members; the appointment of a broker to act in our interests; the rendering of assistance and advice to the State Committee and to the Company in the case of any claims when requested to do so; and an endeavor to keep medical fees in malpractice suits at a reasonable rate'."

It was regularly voted that Dr. George H. King, in view of his long period of practice, be invited to attend the Annual Dinner as a guest of the Society. It was also voted that Dr. Charles W. Cropper, probably the oldest member of the Society, be invited to the Dinner as an Honor Guest.

Report of the Committee on the Costs of Medical Care of the Hudson County Medical Society

This report is summarized as follows:

Majority Report Discussion

(1) We are opposed to this first recommendation because of contract practice and socialization of medicine. With the hospital as the keynote or center of practice it would be impossible to have the personal relationship between patient and physician. Mass production in medicine cannot give the personal service desirable. We are opposed to forceful development of group practice. All municipal and semipublic hospitals receiving support from the public should be opened under equitable regulations and supervision, to all members of the profession in good standing in County Medical Societies. Future hospitals should be smaller because they offer better facilities for education of the profession, closer contact between patient and physician and distribution of medical work among a greater number of physicians.

(2) Basic health services should be limited to the real essential ones only, and Boards of Health should have as their heads only Doctors of Medicine or of Public Health.

(3) The use of insurance or taxation to cover the costs of medical care is opposed because of commercialization of the profession, diminution of personal incentive, responsibility and confidential relationship. Allows politics to enter and places control in non-professional hands. Instigates price cutting and reduces quality of medical service. Cost of care would be increased because 40% used for administration. Voluntary insurance would not cover low income jobs or indigents nor those physically unfit. Compulsory insurance would be amenable to political or corporation intervention and patients identity would be lost.

(4) We recommend the suggestion that the study, evaluation, and coördination of medical service be considered important functions for every State and local community, that agencies be formed to exercise these functions and that the coördination of rural with urban services receive special attention. The Cleveland Public Health Council is especially deserving of study.

(5) Committee agrees with recommendation of greater emphasis on preventive medicine in all its phases in medical education. We agree that an equitable, free, unhampered, democratic plan for

limitation of the practice of the specialties should be sought. An early hospital attachment should be given the young practitioner and the facilities of all hospitals should be made available for Post-Graduate Education, supplemented by similar endeavors on the part of colleges. Opportunities should be provided for clinical bedside instruction at the hospitals. We are opposed to the creation of the class of nurse-midwives. Opportunities should be offered for the systematic training of hospital administrators. We also feel that medical economics should play an important part in the curricula of our colleges and in the activities of our county societies.

MINORITY REPORT DISCUSSION

(1) We agree with the Minority recommendation that Government competition in the practice of medicine be discontinued and its activities restricted to care of indigents, army and navy men, veterans, etc.

(2) We disagree with recommendation No. 2, where the Minority recommends, "That Government care of the indigents be expanded with the ultimate object of relieving the medical profession of this burden." Although it is neither the legal nor moral responsibility of the medical profession to treat any class of citizens free, but has always been the pleasure and right of the profession to perform this service, if the medical profession is to continue to exercise its prerogative of treating the indigent free, thus relieving the public of a tremendous burden, effective means must be employed to obviate flagrant abuse of medical charity.

(3) Same as No. 4 of Majority Report.

(4) We agree "that united attempts be made to restore the general practitioner to the central place in medical practice".

(5, 6, 7) We agree here with the recommendation of the Minority.

The following plans have shown merit and we would recommend further study of them: Suffolk County Plan, Buffalo General Hospital Plan, Vaughan Plan of Detroit, Cleveland Public Health Council.

We agree with the Minority that any plan for the distribution of medical costs must have the following safeguards:

"(1) It must be under the control of the medical profession. (A 'Grievance Board' to settle disputes, having lay representation, is permissible and desirable.)

(2) It must guarantee not only nominal but actual free choice of physician.

(3) It must include all, or a large majority of the members of the county medical society.

(4) The funds must be administered on a non-profit basis.

(5) It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

(6) It should make adequate provision for community care of the indigent.

(7) It must be entirely separate from any plan providing for cash benefits.

(8) It must not require certification of disability by the physician treating the disease or injury."

It was regularly moved, seconded and carried that this report be accepted.

Dr. Leo Mayer, Professor of Orthopedic Surgery, Columbia University, and at the Post-Graduate Hospital, New York City, gave an interesting talk on "Operative Treatment of Traumatic and Paralytic Deformities". His demonstration with the aid of the lantern of the very novel methods used in correcting deformities together with the exhibition of actual results on some patients that were present, proved very enlightening.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

MARCH MEETING

The Mercer County Medical Society met in the Carteret Club on March 8, at 8:30 p. m. with President Proctor presiding. The entire program concerned a Consideration of the Report of the Special Committee, appointed by the President, to submit a résumé with recommendations, if any, of the "Report of the Committee on the Costs of Medical Care."

Dr. C. C. Franklin, Chairman of the Committee, presented an extremely comprehensive review on the report, displaying evidence of a thorough study made by himself and his committee confrères, Drs. Chianese and Fessler.

Dr. Franklin submitted facts and figures concisely and in very plain language; while Dr. Chianese gave us details with definite emphasis upon the figures relating to "Group Payment for Medical Care", through the use of Insurance and Taxation.

Dr. A. J. Fessler spoke on that phase of the problem entitled "The Coördination of Medical Service and Basic Educational Improvements".

The entire report was indeed a master-piece of carefully performed work which brought forth commendatory expressions as well as extensive discussion. Upon conclusion of a thorough discussion of the subject, Dr. Franklin moved that the Society adopt and accept the *Minority Report* and his motion was carried unanimously.

The President appointed Dr. E. B. Beairsto to fill the vacancy on the Membership Committee, occasioned by the death of Dr. M. W. Reddan.

Drs. Scammell, Wm. S. Collier, McGuire and Atkinson were appointed by the President to draw suitable Resolutions on the death of Dr. M. W. Reddan, of Trenton, and Dr. Elston H. Bergen, of Princeton.

The Committee on Post-Graduate study courses reported a completed personnel of Lectures, and that reservations should be made at once.

APRIL MEETING

The Mercer County Medical Society met at the Trenton Country Club, April 12, with President Proctor in the chair.

Dr. Alexander Randall, Professor of Urology, University of Pennsylvania, was introduced and spoke on the subject of "Renal Tuberculosis", reviewing, in a very interesting manner, the complete medical history surrounding development of the several theories regarding tuberculosis of the kidney. The etiology, physiology, symptomatology and pathology were all elaborated upon in an entertaining description, with a final summing-up of the several methods now used in diagnosis and treatment. Discussion followed.

Dr. William L. Wilbur, on behalf of Head Master R. W. Swetland, of Peddie Institute, Hightstown, extended an invitation to the Society to hold a meeting at that Institution.

Dr. R. G. Stone, Superintendent of the New Jersey State Hospital, invited all members of the Society to attend a meeting at the Hospital on April 21, at which time Dr. Clements C. Fry, of the Department of Psychiatry and Mental Hygiene, of Yale University, will be the Guest Speaker.

Drs. Henry J. Majeski and William V. Carroll were elected Active Members, and Drs. Charles F. Cella, William A. Chesner, J. B. Spradley, P. B. Reisinger, Elizabeth L. Martin Associate Members.

MIDDLESEX COUNTY

Medical Section of Rutgers Club

John H. Rowland, M.D., Secretary

February Meeting

The regular monthly meeting of the Medical Section of Rutgers Club was held February 24, at the Alumni House, Queens Campus, Rutgers University, with 21 members present and Dr. Gutmann presiding.

The speaker of the evening was Dr. M. S. Brody, of New Brunswick, whose subject was "Endoscopic Resection of the Prostate Gland", illustrated with lantern slides. Dr. Brody presented very clearly the diagnosis, indications for endoscopic resection, preoperative preparation, convalescence, contrasting results, so far as cure and death rate are concerned, and relation to prostatic conditions. Discussion was opened by Dr. McKiernan, urologist at Middlesex Hospital and St. Peter's Hospital, New Brunswick, and after the free discussion which followed, we were entertained and refreshed by the entertainment committee: Drs. Haight, Haywood, Hoffman and Howley.

The meeting adjourned spontaneously.

Meeting of March 24

The Annual Meeting of the Medical Section of the Rutgers Club was held on Friday evening, March 24, at the Alumni House, Queens Campus, Rutgers University. In the absence of Dr. Gutmann, Dr. Howley presided. Those present were: Drs. Brody, Cronk, Feher, Haywood, Howley, Johnson, Karshmer, Klein, Kler, Leonard, Merrill, Nafey, Rothschild, Rowland and Smith. The minutes of the previous meeting were read and approved.

The Auditing Committee reported that the books of the Treasurer had been examined and found correct.

Resignation of Dr. Chester T. Brown was accepted with regret.

Drs. C. R. Toy and P. S. Avery were elected to membership in the Club. Leave of absence was granted Dr. Nieman. Dr. Saulsberry was made an Honorary Member.

The Treasurer reported a balance of $170.94 on hand, as of March 23, 1933.

Officers elected for the ensuing year were: Dr. Howley, Chairman; Dr. Voorhees, Vice-Chairman; Dr. Rowland, Secretary and Treasurer.

Meeting of March 31

The regular monthly meeting of the Medical Section of the Rutgers Club was held on Friday evening, March 31, at the Alumni House, Queens Campus, Rutgers University, with Dr. Howley presiding. Those present were: Drs. Kler, Karshmer, Gutmann, Leonard, Johnson, Brody, Toy, Faulkingham, Brown, Voorhees, Sherman, Merrill, Scott, McKiernan and Rowland.

The resignation of Dr. Voorhees as Vice-Chairman was received and accepted with regret, and Dr. Faulkingham was nominated and elected Vice-Chairman for the ensuing year.

There being no further business, the speaker of the evening, Dr. Alan Boyden, Associate Professor of Zoology at Rutgers University, was introduced and spoke to us about "Heredity as Related to Medicine". The subject was freely discussed by the members.

At the conclusion of the discussion, Drs. Brown, Johnson and Gutmann spoke on various subjects which they found to be of considerable interest at the recent Annual Meeting of the College of Physicians, at Montreal.

At a late hour, the meeting adjourned and the members were entertained by the Entertainment Committee, composed of Drs. Klein, Johnson, Karshmer and Leonard.

MONMOUTH COUNTY

R. A. MacKenzie, M.D., Reporter

February Meeting

The regular monthly meeting of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital, Long Branch, on Wednesday evening, February 22, with President Robert E. Watkins presiding. Dr. Wm. Shanik, of Asbury Park, was elected to membership. The report of the Executive Committee meeting, held February 13, copies of which had been mailed in the monthly bulletin to each member of the Society, was opened for discussion. Considerable interest was expressed in the questions proposed by Dr. Stanley Nichols, as Chairman of the Public Health Committee of the State Medical Society, concerning public health problems, particularly the immunization work among children of pre-school age. He asked for an expression of opinion, whether this work should be done by the establishment of new clinics, the extension of present existing clinics for charity and part-pay patients, or whether the work should be assigned and divided among the doctors to be done in their offices. After rather extended discussion, it was agreed that the matter should be investigated by a committee to be appointed by President Watkins and submitted at the next meeting.

A worth-while suggestion advanced in the Executive Committee meeting, in reference to the desire of the State and County Societies to stabilize or increase membership at this time, was a proposal to hold at least one meeting yearly of the Monmouth County Medical Society to which all eligible practicing physicians in the county will be invited. At this meeting the aims and accomplishments of the organization are to be mentioned and practitioners who are not enrolled may be invited to make application for membership.

The Monmouth County Society was honored at this meeting by the presence of Dr. A. Haines Lippincott, President of the State Medical Society; who, having been introduced, delivered a short address. The 40 or more members present provided an enthusiastic audience.

The Scientific Program for the evening consisted in an able presentation by Dr. Bradley Coley, on the subject "Inguinal Hernia, Its Surgical and Non-Surgical Treatment." Dr. Coley, who is Attending Surgeon at the Ruptured and Crippled, and Memorial, Hospitals, in New York City, illustrated his talk with lantern slides. He emphasized the importance of correct diagnosis of the hernia type and pointed out the differences in treatment between direct and indirect hernias. He pointed out the ease of operative repair in children, and satisfactory results following operation upon young adults, in contrast with the difficulties encountered and the less satisfactory end-results in patients who seek surgical relief as the last resort following prolonged use of trusses In conclusion, Dr. Coley described in detail the use of fascial strips after the method of Galli in repair of extensive direct or recurrent inguinal hernias.

March Meeting

The regular March Meeting of the Monmouth County Medical Society was held on Wednesday evening, March 22, in the District Court Rooms, in the Electric Building, Asbury Park. This was

a *joint meeting* with the Monmouth County Dental Society, and invitations to attend were sent also to the Woman's Auxiliary to the Medical Society, Social Service Workers, Nurses, and all other interested persons. This being a Special Meeting, no business was transacted.

Dr. A. C. Morgan, of Philadelphia, a member of the National Committee on the Costs of Medical Care, was the speaker of the evening; and, at the conclusion of his address questions were asked and a very interesting discussion of medical economics followed.

Dr. Morgan's remarks are not reported here because his talk followed rather closely his other presentations on the same subject, which have been previously set down in this Journal and elsewhere. In the March 1933 issue of our State Society Journal, Dr. J. M. Kuder, Reporter for Burlington County, gave what is apparently a transcript of an address made by Dr. Morgan before the Burlington County Medical Society in February, and discussion resulting therefrom. I wish to thank Dr. Kuder for this excellent reportorial accomplishment.

With their interest aroused by Dr. Morgan's discussion, no less than a dozen members of the Monmouth County Medical Society attended the Fourth Councilor District Meeting in Camden on Tuesday evening, April 4, and very much enjoyed the constructive suggestions made there by Dr. Seth Brumm.

Asbury Park Medical Society

The February Meeting of the Asbury Park Medical Society was held, February 14, at the Fitkin Morgan Memorial Hospital. Dr. Joseph Wiener, of Asbury Park, reported his impressions of the Convention of the American College of Physicians, held in Montreal, from which he had just returned.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

March Meeting

The regular quarterly meeting of the Morris County Medical Society was held the evening of Thursday, March 16, at The New Jersey State Hospital at Greystone Park. President Pinckney presided over a gratifying attendance of some 65 members and guests.

Routine business included the reading and approval of the minutes of the last regular meeting of December 15, 1932, and the interim proceedings of the Executive Committee and special meetings of the Society, some features of which were discussed.

The question of "specialization" was discussed and upon a recommendation that the Committee on Specialization be discharged and the matter dropped, that action was unanimously taken and the Secretary was instructed to so notify the Secretary of the State Society.

The Credentials Committee, having reported favorably upon 2 candidates for membership, Dr. Archie Crandell, of Greystone Park, and Dr. Bror Troedsen, of Mendham, they were unanimously elected.

Dr. Arthur L. Holland, Clinical Professor of Medicine at Cornell, gave a very interesting talk on "Gall-Bladder Indigestion" which was illuminated and elucidated by lantern slides and x-ray pictures that were passed around for inspection.

The speaker of the evening prefaced his discourse by asking those present to forget that they had been in practice for any period of years and to go back to their third year in medical school, as he was going to talk on that level; that the subject of indigestion is most interesting and at the same time possibly one of the most neglected things, in which, generally, very little effort is made to get at the basic cause; describing how it might be caused by misunderstanding even at the breakfast table, and how the emotions react on increasing or decreasing digestive motility; and citing interesting conclusions found during normal, abnormal or subnormal emotional periods of the patient. The fields of diagnosis, treatments, diets and surgery were entered into thoroughly, and various case histories were presented.

The discourse elicited healthful discussion and various questions were asked by members and answered by Dr. Holland; those taking part in the discussion including Drs. Robin, Lathrope, Rice, Frost, Collins, Seward, Schmitz, Christian, Haven and Reed, all of whom expressed commendation of the speaker for his presentation of the subject.

April Meeting

A special meeting of the Morris County Medical Society was held at the State Hospital, at Greystone Park, the evening of Thursday, April 20, and President Pinckney had the pleasure of presiding over an attendance of 50 members and guests.

The guest speaker was Dr. Edmund B. Piper, Professor of Obstetrics, University of Pennsylvania, who announced his subject as the "Present Status of Operative Interference in Obstetrics with Discussion of High and Low Cesarean Operations" and covered his subject in an interesting and impressive manner, well calculated to compel studious attention.

Dr. Piper drew from his broad experience to bring out various important points. Speaking of contraindications, he said that the 2 big ones are the *individual* and the *place;* that he could not think of a normal physician interfering with spontaneous delivery at any time; that he thought the chief thing is the individual patient; stressing the uncertainty of pelvic measurements because one woman may have a 9 lb. child, and another woman a 5 lb. child, which makes it difficult to determine the relation of the pelvis to what is going to try to come through. How can one, therefore, be didactic? He was convinced that most of the intercranial hemorrhages occur before forceps or operative intervention takes place; not in all but more in the protracted, long-drawn-out labors, than in the quick labor and forceps; citing 6 consecutive cases of puerperal sepsis seen in hospitals, all being persistent labors with lowered resistance which had not been examined. He was convinced that infection is the cause of lowered resistance, and he emphasized the importance of keeping up the resistance. Lowering of resistance may also be caused by the mental attitude of the woman; citing a case where a girl, who did not care what became of her, with her resistance gone picked up sepsis; and citing, opposed to this, how in certain quarters women can have babies on a bed of newspapers covered with filth, and will meet the physician at the door the fourth day. An understanding of the normal functions and mechanisms of childbirth was strongly emphasized. The technic in use of forceps was shown and also the procedure for Cesarean.

Very great appreciation of the speaker and his discourse was manifested and the discussion was entered into by Drs. Williams, McMahon, Frost and Pel'et, the latter a guest from Sussex County; and the questions asked were freely and fully answered by the speaker.

After the formal meeting, which was given up wholly to the speaker of the evening, refreshments were served and enjoyed in the cafeteria.

OCEAN COUNTY

Eugene G. Herbener, M.D., Reporter

The regular meeting of the Ocean County Medical Society was held on March 8, at 7 p. m., at the Paul Kimball Hospital, in Lakewood.

The President, Dr. A. Goldstein, presided. The Secretary read the minutes of the previous meeting, which were approved as read. Dr. Goldstein then introduced our new member, Dr. W. G. Hayden, under the classification of an Eye-Specialist.

The President then requested the Secretary to read the communications, among which there was one from the State Medical Society bearing on the topic "The Specialist". After a lengthy discussion of this by all members present, the President appointed Dr. Harold Disbrow, Dr. Fred Bunnell and Dr. Eugene Herbener to serve as the Committee to receive applications for recognition as "specialists" in their particular branch. The communication from Dr. Niehols, requesting that the Ocean County Medical Society appoint a physician to represent our Society at the State Conference on Pediatrics, was complied with by the President appointing Dr. Blackwell Sawyer, of Toms River, to fill that position.

An interesting discussion on the Cost of Medical Care then took place. Nothing definite was agreed upon. On motion by one of the members, an effort was made to ascertain those who will be able to attend the Councilor meeting to be held during April.

Matters pertaining to the local Society were discussed and disposed of satisfactorily. A vote of thanks was extended to Miss Elizabeth Miller, Superintendent of Paul Kimball Hospital, for the courtesy shown us and the very fine Supper enjoyed by all.

Dr. Herbert Willis, of Beach Haven, Assemblyman for Ocean County, gave us a lengthy talk on Legislation proposed at the last session of the Legislature. All matters having been disposed of, it was moved and carried that we adjourn.

PASSAIC COUNTY

Wayne W. Hall, M D., Reporter

The regular meeting of the Passaic County Medical Society was held at Public School No. 6, Paterson, Thursday, March 9, at 8:30 p. m., as a joint session with the Paterson League for the Hard of Hearing, planned to put before the Medical Profession and those interested the work being done and the splendid results obtained through the efforts of those concerned in this more than worthwhile movement. The program was as follows:

(1) Aims and Purposes of the Paterson League for the Hard of Hearing—by Dr. Elias J. Marsh, Attending Ophthalmologist, Paterson General Hospital, and one of the founders of the League in Paterson.

(2) Lip Reading—by Miss Genevieve Foley, Instructor in Lip Reading, the Paterson League for the Hard of Hearing. Miss Foley stressed the newer psychologic methods used in this work.

(3) Deafness in Childhood—by Dr. E. A. Atwood, Attending Oto-laryngologist, Paterson General Hospital.

(4) Study and Treatment of Diseases of the Ear Which Cause Deafness—by Dr. Edmund Prince Fowler, Surgeon Director, Manhattan Eye, Ear and Throat Hospital, New York City. Dr. Fowler was one of the pioneers in this movement and his talk was most instructive and revealing. It was particularly helpful for those laymen present who suffered from deafness. The hall was specially wired for and the discussions were carried on through the microphone for their benefit.

During the short business meeting following, Dr. McBride again called attention to efforts to oppose Bill S. 126 mentioned in the minutes of the previous meeting, and asked all those interested to write Senator Barbour in reference to the matter.

The meeting adjourned at 10:30 p. m.

SALEM COUNTY

William H. James, M.D., Reporter

The regular April meeting of the Salem County Medical Society was held at the Memorial Hospital, April 12, at 9 p. m., with President Hilliard in the Chair.

The business of the Society was conducted in the regular order, after which we had the pleasure of hearing a very interesting paper by C. L. Fleming, of Pennsgrove, entitled "Gastro-Enteritis in Infancy".

After discussion by the members present, a rising vote of thanks was given to Dr. Fleming.

A discussion on *Medical Economics* occupied considerable time because there were various views to be expressed.

Dr. H. F. Suter, of Pennsgrove, was elected to full membership in the Society.

After the meeting, members enjoyed a luncheon in the main dining room of the hospital.

The next meeting will be the Annual Planked Shad Dinner at the Salem Country Club in May; date to be announced later.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

March Meeting

A largely attended Joint Meeting of the Clinical Society and the Elizabeth Pharmaceutical Association was held at the Elizabeth General Hospital on the evening of March 21, with Dr. Emil Stein presiding.

Mr. Robert G. Lyons spoke of the problems with which doctors and druggists are mutually concerned.

Mr. Graham McCloskey, President of our State Board of Pharmacy, said that we have in this State approximately 2000 drug stores, 4000 registered pharmacists, and about 5000 "general stores" selling drugs and patent medicines. The functions of the Pharmacy Board include: Examination of applicants for registration as pharmacists; registration and supervision of apprentices; enforcement of the Pharmacy Act; inspection of pharmacies and other places where drugs and medicines are kept, sold or dispensed; determination of the quality of drugs and medicines; and formulation of standards of pharmaceutic education. Organized pharmacy is striving to maintain its rightful place among the honored professions and adhering strictly to its code of ethics, in the hope that racketeers who encroached upon professional pharmacy will be driven out of existence.

Mr. Robert P. Fischelis, Secretary and Chief Chemist of the Board of Pharmacy of New Jersey, told of the many activities of that organization, including the study of policies mutually affecting druggists and doctors.

Dr. C. H. Schlichter made a plea for the prescribing of standardized U. S. P. and N. F. preparations, instead of more expensive and less efficacious proprietary articles.

Dr. J. S. Green spoke of the dangers of counter-prescribing by druggists and said that on occasion their advice to a customer to "take a good dose of castor oil" had been, unfortunately, the cause of a ruptured appendix. He also quoted the late Dr. Jacobi to the effect that a physician unable to formulate his prescriptions from standard remedies, was not fit to practice medicine.

Discussion followed by Drs. Stern, Wagner, Bunting, Gerandasy, Livengood and Mr. Frohwein. This unusual meeting brought out many points of interest, the discussion of which was helpful to the members of both professions. On motion, a rising vote of thanks was extended the druggists for providing such good speakers and other features that made the meeting so helpful; among which, was a splendid display of U. S. P. and N. F. preparations.

After adjournment, a collation was served and a social hour enjoyed.

April Meeting

Despite the long continued rain, 65 members attended the regular meeting of the Union County Medical Society, at Muhlenburg Hospital, Plainfield, on the evening of April 12, with Dr. Emil Stein presiding.

Dr. C. C. Beling was cordially welcomed and made a brief address, relating his activities as Councilor of the First District.

The Scientific Program was conducted by members from Plainfield, as follows: (1) A Hernia Containing the Sigmoid; (2) Intestinal Obstruction Due to Adhesive Bands; (3) Hernia Causing Intestinal Obstruction; (4) Hydronephrosis; (5) Spina Bifida. These patients were exhibited and their interesting ailments and successful treatment were fully discussed.

Dr. George Laird, on behalf of the Public Health Relations Committee, submitted a report recommending the adoption of the Minority Report of the Committee on Costs of Medical Care, and the Society endorsed this report. Our Committee was continued and asked to try to find means to put its recommendations into effect; and to submit a further report at the next meeting.

The Society went on record as favoring the Bill, now pending in the Legislature, for sterilization of the hopelessly insane.

The Nominating Committee submitted the following names for Delegates and Alternates to the Annual Meeting of the State Society to be held at Atlantic City, June 6-9. All of those nominated were elected:

Delegates: J. B. Harrison, George S. Laird, S. T. Quinn, C. H. Schlichter, Isidore Stein, C. A. Brokaw, Emil Stein, John Runnells, George Orton, Harry H. Bowles, Thomas P. Prout, H. V. Hubbard, Norman W. Currie, Harold F. Johnson.

Alternates: L. H. Leggett, Frank Williams, Harry Bloch, Jacob Reiner, G. W. H. Horre, Arthur Casilli, Ronald T. Blythe, Charles A. Hoffman, E. W. Lance, Watson B. Morris, Henry Dengler, James G. Boyes, Carl Bishop, John D. Tidaback, Irving Lerman and Elmer Weigel.

A new Nominating Committee, consisting of Drs. J. Reiner, Stanton Davis and N. W. Currie, was elected.

Drs. Lee R. Herrington, Westfield; Isadore Frimmer, Elizabeth and Samuel Tilles, Cranford, were elected to membership, and 3 others were proposed for consideration at the next meeting.

At the close of the session a collation was served and a social hour enjoyed.

Obituaries

REDDAN, Martin W., 126 West State Street, Trenton, died at his residence on March 1, 1933, after an illness of approximately 1 year.

Dr. Reddan was born in Trenton in 1870. After completing his grammar school education, he became a printer. Ambitious to enter a professional career, he first studied dentistry, but after 9 months found medicine more to his liking.

The following Fall Dr. Reddan entered the Jefferson Medical College and was graduated with the degree of M.D. in 1900. He returned to Trenton as an intern at Mercer Hospital, but at the end of 6 months transferred to St. Francis Hospital, where he stayed for 1 year.

It was while Dr. Reddan was serving as an intern at Mercer Hospital that he met the future Mrs. Reddan, then Miss Blanche Anderson, supervisor of nurses in the institution.



MARTIN W. REDDAN

After following the practice of general medicine for several years, Dr. Reddan specialized in surgery, completing his studies in Vienna, Austria, and spending some time as a Visiting Surgeon in the hospitals of London and Paris. He rapidly gained prominence through his work and was widely sought as a consultant.

In 1912 he was appointed Medical Director of the New Jersey State Prison and continued service in that capacity until his death. One of the outstanding accomplishments during his administration there, was an operation he performed on the brain of Jones Szikely, which transformed the prisoner from a man of maniacal tendencies into a model of docility; an operation which attracted international attention at the time. Szkiley, who was subsequently paroled, died last year.

Dr. Reddan held the rank of Major in the Medical Reserve Corps U. S. Army, having won his grade by particularly meritorious work while in charge

of the Base Hospital at Mieu Chateau, as a brain specialist, during the World War.

Dr. Reddan was a member of the American College of Surgeons, American Medical Association, Society of Surgeons of New Jersey, Mercer County Medical Society, Chairman of the Committee of Arrangements of the New Jersey Medical Society, Medical Club of Philadelphia, Trenton Council, K. of C.; Trenton Historical Society, Trenton Chamber of Commerce, American Legion, Carteret Club, Democratic League, Disabled Emergency Officers of the World War. Wayside Club, Rotary Club, American Legion and the 40-and-8.

Dr. Reddan is survived by his wife; 2 daughters, Mrs. Crawford Jamieson and Miss Doris Reddan; 1 son, Martin W. Reddan, Jr., a student at the Harvard Graduate School of Business Administration; 3 brothers, the Rev. William J. Reddan, State Budget Commissioner John A. Reddan and Frank A. Reddan, and 1 sister, Miss Anna A. Reddan.

MENTZER, Clayton A., Health Officer of Hillside, died at 8.30 p. m., March 19, in the Elizabeth General Hospital, of injuries received the previous night, when he was struck by a car as he was crossing Frelinghuysen Avenue, Newark, near the Elizabeth line. With a fractured skull and internal lesions, he was promptly taken to the hospital, but died without having regained consciousness.

Dr. Mentzer was 46 years old, and lived at 42 Hollywood Avenue, Hillside. He was born in Waynesboro, Pa., the son of Mr. and Mrs. William Mentzer. He held degrees from Hahnemann Medical College, Dickinson Seminary, and the University of Pennsylvania, and took special studies in diseases of the eye, ear, nose and throat.

He began the practice of medicine in Maryland, and settled in Hillside in 1921. Dr. Mentzer was a member of the Staff of the Alexian Brothers Hospital and of the Dispensary Staff of the Elizabeth General Hospital. He served with the Newark Dispensary Clinic for several years.

Dr. Mentzer was a member of the American Medical Association, Acacia Lodge, F. and A. M., of Maryland; Hillside Lions Club; the South Side Republican Club; and Phi Upsilon Rho Fraternity of Hahnemann Medical College. He was an Honorary Member of the P. B. A. and the F. M. B. A.

Both the Board of Health and the Township Committee adopted resolutions expressing deep regret over the loss of Dr. Mentzer, and extending sympathy to the family. It was ordered that the flag at the municipal building be flown at half mast for 30 days, and that the building be draped for the same length of time.

ROBINSON, Moe, of 68 Hillside Road, Elizabeth, on a vacation trip to the West Indies by the S. S. Lafayette of the French Line, died on March 3, of pneumonia as a complication of a serious tropical sunburn.

Dr. Robinson was 47 years old. He was born in Elizabeth, December 26, 1885, and was a graduate of Public School 2, Battin High School, and the University of Maryland Medical School. His office was at 1016 East Grand Street, adjoining the home of his mother, Mrs. Rose Robinson.

Dr. Robinson was one of Elizabeth's best known physicians. He had an extensive practice, drawing clients from a wide area, and was active in hospital work. He gave considerable service to the Alexian Brothers' Hospital and was chairman of the institution's standardization committee. He was a member of the clinical society of Elizabeth General Hospital and also of the clinical staff of St. Elizabeth Hospital. He was a member of the Union County Medical Association, the New Jersey Medical Society and the American Medical Association. His lodge affiliations included membership in Tyrian Lodge, F. & A. M., and Elizabeth Lodge 289, B. P. O. E. He was a trustee of Temple B'nai Israel.

The death is reported of Dr. Irving D. Williams, an esteemed member of the Essex County Medical Society, on April 6, 1933.

Resolutions on the Death of Dr. Moe Robinson, Adopted at a Special Meeting of the Union County Medical Society

Whereas, The Almighty God has taken by death, Dr. Moe Robinson, after 24 years as a member of the Union County Medical Society, practicing his profession during all those years with that zeal and honesty which brings honor in its wake; and,

Whereas, his devotion to his hospital responsibilities, and his work for the advancement of hospital standardization is known to all, never being satisfied until the best was obtained; and,

Whereas, we keenly feel his loss as a physician and a friend, and can realize, in part, the grief and sorrow of his family at this time;

Be it resolved, that a part of the record of this meeting be devoted to his memory, and this resolution be placed thereon, and a copy be sent to his bereaved wife and family.

Done at Elizabeth, on the sixteenth day of March 1933.

Committee:
William E. Boozan
Abraham Rose
William MacCallon

Resolutions Passed by the Union County Medical Society, March 17, 1933

The Union County Medical Society, having learned of the sudden passing of Dr. William H. Anthony, wishes herewith to express to Mrs. Anthony and the other members of his family, its deep sorrow at the loss of this genial member and well-tried physician; and its sincerest sympathy for those bereft by his going. And it is, therefore,

Resolved: That these sentiments be embodied in the Minutes of the Society, conveyed to Dr. Anthony's family, and published as is becoming.

(Signed) Thomas H. Leggett, Jr.
Edward H. Krans
Elmer Peter Weigel

Resolutions on the Death of Dr. Mentzer, Adopted by the Union County Medical Society, March 22, 1933

In the sudden passing of one of our colleagues, Dr. Clayton A. Mentzer, from our midst, the medical profession, the Township of Hillside, and the surrounding community, have suffered an irreparable loss.

Active in the general practice of his profession and as Health Officer of Hillside, he made numerous friends and was held in high esteem by his many patients. Therefore, be it:

Resolved, that we express our deep sense of regret at the loss of a fellow member of our Society and express to his family our heartfelt sympathy; and be it further

Resolved, that we incorporate this resolution upon the minutes of the Society in his memory.

Henry J. Konzelman, M.D.
L. G. Reisler, M.D.
Jerome Reich, M.D.

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RECOMMENDATION CONCERNING THE SOLICITATION OF PATIENTS

(The Weekly Roster and Medical Digest)

The question of ethics in relation to the solicitation of patients under certain circumstances, especially for the purpose of advising measures for the prevention of disease, should be clearly interpreted by the society in order that its members may be free to act without fear of criticism.

Members should be advised that it is not only ethical, but that it is also their duty in the interest of public health *to solicit their patients to present themselves for periodic health examination, for immunization against small-pox, diphtheria, etc.,* and to coöperate with the Department of Public Health of Philadelphia in all matters of preventive medicine.—From Report of Committee on Medical Economics adopted by the Board of Directors.

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The Clinical Laboratory, 33 Lincoln Park, Newark, has been receiving many replies to their questionnaire on the results of the Zondek-Ascheim test for pregnancy (Friedman Rabbit Modification) and requests that all physicians who have not yet returned the records, do so.

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SCIENCE AND RACE

(New York Times)

When the University of Oxford thought that Euclid was the sum and substance of higher mathematics and still looked upon bathing as a heathen custom, Moorish scientists were both bathing and laying the foundation of modern culture. "They are of a cold temperament and never reach maturity," said the learned Said of Toledo, speaking of the Nordic barbarians. "They are of a great stature and of a white color. But they lack all sharpness of wit and penetration of intellect." No doubt he and his contemporaries of Sevilla and Cordoba, who were developing spherical trigonometry, would be amazed to see what has become of their own people and of the despised northmen. The Moors were in their prime when they were freely intermarrying with conquered infidels, and declined when the day of conquest and emigration was over. Such vicissitudes cause wonder about the rôle of race in human progress.

Ask an anthropologist to define a race and he gives us a muddy mixture of physical characteristics, genetics, folkways and geographical origins. Ask the geneticist and he is apt to talk in terms of a biological species—something especially difficult to determine in the case of such a mongrel as the Aryan beloved of the Nazis. Ask the politician and he advances theories which, he mistakenly believes have the sanction of both physical anthropology and genetics.

No one is able exactly to tell us what a race is. White, black, yellow? Flate nose and high nose, thick lips and thin lips? Squatness and tallness? These are not conclusive. Despite the obvious differences between Asiatics and Europeans, Africans and Eskimos, we find everywhere gradations not due to racial mixtures. Many a pure-blooded Mongol has decided European traits; many a pure European looks as if his grandfather had been a Japanese.

The biochemist attacks the problem with blood agglutination tests. Blood will tell—but not everything. He discovers evidence of a single pure strain long ago. Nowhere is it to be found today—not even in savage tribes.

Turn to the geneticist. Drs. Davenport and Steggarada of the Carnegie Institution of Washington have studied the whites and blacks of Jamaica, where all live in the same environment. Small differences in favor of the whites were detected—not enough, in the opinion of Professor Hogben, to justify the setting up of legislative policies and social barriers. Corresponding studies made in South Africa indicate that the children of Hottentots and Boers are superior to their parents.

The psychologists are no clearer. When Professor Brigham was engaged in assessing the intelligence quotient of children of different racial stocks on the basis of American Army tests one professorial enthusiast predicted that the final result would be sufficient "to convince the most pronounced skeptic" of Nordic superiority. It was a shock when Professor Brigham branded his own studies as valueless from this standpoint.

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BOX 380, HADDONFIELD NEW JERSEY

HARTMAN TO RECEIVE SCHOELLKOPF MEDAL

(New York Times, April 7)

The Schoellkopf medal for 1933 has been awarded to Dr. Frank A. Hartman, Professor of Physiology at the University of Buffalo and discoverer of cortin, remedy in the treatment of the previously incurable Addison's disease. This medal is given annually by the Western New York Section of the American Chemical Society for the outstanding achievement of science.

The announcement, made in the society's magazine, said that the presentation would be made at the May meeting.

Dr. Hartman revealed his discovery of cortin in 1927. The substance is derived from the adrenal glands. While the field of its uses has not been mapped, Dr. Hartman has found it effective in a variety of diseases. As a treatment for Addison's disease, cortin has been ranked with insulin and other epoch-marking discoveries.

Dr. Hartman's announcement of his discovery followed a 16 year search for a cure for Addison's disease. In 1931 he received $5,000 from the Carnegie Institution to continue his experiments with cortin.

The Schoellkopf medal was created in 1930 by Jacob F. Schoellkopf, Sr., industrialist, member of a pioneer Niagara frontier family.

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B. S. Pollak	" "	1933
Walt P. Conaway	" "	1935
E. R. Mulford	" "	1933

Alternate Delegates

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Philip Marvel	" "	1935
S. B. English	" "	1933
S. T. Quinn	" "	1933

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Linn Emerson, Orange	" "	1935
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James S. Green	" "	1935
Alfred Stahl	" "	1934
Wells P. Eagleton	" "	1933
William J. Sweeney	" "	1935
William G. Herrman	" "	1937

Committee on Program and Arrangements

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William J. Carrington, Atlantic City	" "	1935
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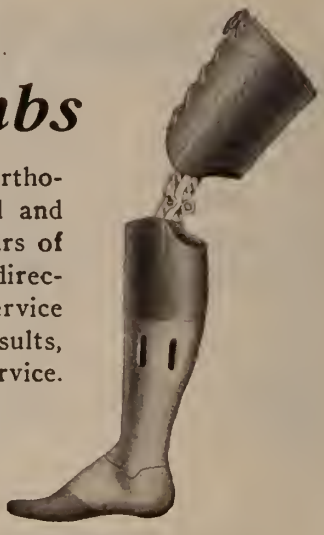
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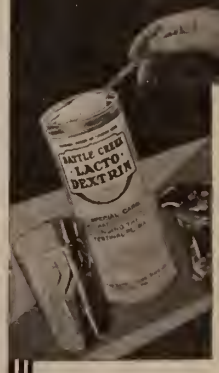
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Supplement to the Journal of the Medical Society of New Jersey, May, 1933

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MAY 1933
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OFFICIAL LIST

OF THE

FELLOWS, OFFICERS, DELEGATES AND MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1933

Prepared by J. Bennett Morrison, Secretary, assisted by the Secretaries and Treasurers of the County Societies.

This list is composed from the identical lists submitted by the Treasurers of the various County Medical Associations. If there are any errors in your name or address please take the matter up with the Treasurer of your County Medical Society and have the proper correction made so that the error will not be carried on next year.

The Alphabetical List is compiled in the office of the Secretary.

FELLOWS

The dates represent the year of election as President. Those marked thus (*) are deceased.

*Robert McKean 1766
*William Burnett 1767
*John Cochran 1768
*Nathaniel Scudder 1770
*Isaac Smith 1771
*James Newell 1772
*Absalom Bainbridge 1773
*Thomas Wiggins 1774
*Hezekiah Stites 1775

* * * * * *

*John Beatty 1782
*Thomas Barber 1783
*Lawrence Van Derveer 1784
*Moses Bloomfield 1785
*William Burnett 1786
*Jonathan Elmer 1787
*James Stratton 1788
*Moses Scott 1789
*John Griffith 1790
*Lewis Dunham 1791
*Isaac Harris 1792

* * * * * *

*Elisha Newell 1795

* * * * * *

*Jonathan F. Morris 1807
*Peter I. Stryker 1808
*Lewis Morgan 1809
*Lewis Condict 1810
*Charles Smith 1811
*Matthias H. Williamson 1812
*Samuel Forman 1814
*John Van Cleve 1815
*Lewis Dunham 1816
*Peter I. Stryker 1817
*John Van Cleve 1818
*Lewis Condict 1819
*James Lee 1820
*William G. Reynolds 1821
*Augustus R. Taylor 1822
*William B. Ewing 1823
*Peter I. Stryker 1824
*Gilbert S. Woodhull 1825
*William D. McKissack 1826
*Isaac Pierson 1827
*Jeptha B. Munn 1828
*John W. Craig 1829
*Augustus R. Taylor 1830
*Thomas Yarrow 1831
*Fitz Randolph Smith 1832
*William Forman 1833
*Samuel Hayes 1834
*Abraham P. Hagerman 1835
*Henry Van Derveer 1836
*Lyndon A. Smith 1837
*Benjamin H. Stratton 1838
*Jabez G. Goble 1839
*Thomas P. Stewart 1840
*Fred S. Schenck 1841
*Zachariah Read 1842
*Abraham Skillman 1843
*George R. Chetwood 1844
*Robert S. Smith 1845
*Charles Hannah 1846
*Jacob T. B. Skillman 1847
*Samuel H. Pennington 1848
*Joseph Fithian 1849
*Elias J. Marsh 1850
*John H. Phillips 1851
*Othniel H. Taylor 1852
*Samuel Lilly 1853
*Alfred B. Dayton 1854
*James B. Coleman 1855
*Richard M. Cooper 1856
*Thomas Ryerson 1857
*Isaac P. Coleman 1858
*John R. Sickler 1859

FELLOWS—Continued

*William Elmer 1860
*John Blane 1861
*John Woolverton 1862
*Theo. R. Varick 1863
*Ezra M. Hunt 1864
*Abraham Coles 1865
*Benjamin R. Bateman 1866
*John C. Johnson 1867
*Thomas J. Corson 1868
*William Pierson 1869
*Thomas F. Cullen 1870
*Charles Hasbrouck 1871
*Franklin Gauntt 1872
*Thomas J. Thomason 1873
*George H. Larison 1874
*William O'Gorman 1875
*John V. Schenck 1876
*Henry R. Baldwin 1877
*John S. Cook 1878
*Alexander W. Rogers 1879
*Alexander N. Dougherty 1880
*Lewis W. Oakley 1881
*John W. Snowden 1882
*Stephen Wickes 1883
*Phanett C. Barker 1884
*Joseph Parrish 1885
*Charles J. Kipp 1886
*John W. Ward 1887
*H. Genet Taylor 1888
*Beniah A. Watson 1889
*James S. Green 1890
*Elias J. Marsh 1891
*George T. Welch 1892
*John G. Ryerson 1893
*Obadiah H. Sproul 1894
*William Elmer 1895
*Thomas J. Smith 1896
*David C. English 1897
*Claudius R. P. Fisher 1898
*Luther M. Halsey 1899
*William Pierson 1900
*John D. McGill 1901
*Edmund L. B. Godfrey 1902
*Henry Mitchell 1903
*Walter B. Johnson 1904
*Henry W. Elmer 1905
Alexander Marcy, Jr. 1906
Edward J. Ill 1907
*David St. John 1908
*Benjamin A. Waddington 1909
*Thomas H. Mackenzie 1910
*Daniel Strock 1911
*Norton L. Wilson 1912
*Enoch Hollingshead 1913
*Frank D. Gray 1914
*William J. Chandler 1915
Philip Marvel 1916
William G. Schauffler 1917
Thomas W. Harvey 1918
*Gordon K. Dickinson 1919
*Philander A. Harris 1920
Henry B. Costill 1921
*James Hunter, Jr. 1922
Wells P. Eagleton 1923
*Archibald Mercer 1924
Lucius F. Donohoe 1925
James S. Green 1926
Walt P. Conaway 1927
Ephraim R. Mulford 1928
Andrew F. McBride 1929
George N. J. Sommer 1930
John F. Hagerty 1931
A. Haines Lippincott 1932

HONORARY MEMBERS

*David Hosack, New York 1827
*John W. Francis, New York 1827
*John Condict, Orange, N. J. 1830
*Usher Parsons, Rhode Island 1839
*Reuben D. Murphy, Cincinnati 1839
*Alban G. Smith, New York 1839
*Willard Parker, New York 1842
*Valentine Mott, New York 1843
*Johathan Knight, New Haven 1848
*Nathaniel Chapman, Philadelphia 1848
*John H. Stephens, New York 1848
*John C. Warren, Boston 1849
*Lewis C. Beck, New York 1850
*John C. Torrey, New York 1850
*George B. Wood, Philadelphia 1853
*Horace A. Buttolph, Short Hills, N. J. 1854
*Ashbel Woodward, Franklin, Conn. 1861
*Thomas W. Blatchford, Troy, N. Y. 1866
*Jeremiah S. English, Menalapan, N. J. 1867
*Stephen Wickes, Orange, N. J. 1868
*Samuel Oakley, Vanderpool, Albany, N. Y. 1872
*Joseph Parrish, Burlington, N. J. 1872
*Ferris, Jacobs, Lelhi, N. Y. 1872
*Charles A. Lindsley, New Haven, Conn. 1872
*William Pepper, Philadelphia 1876
*S. Weir Mitchell, Philadelphia 1876
*Cyrus F. Brackett, Princeton, N. J. 1880
*Joseph C. Hutchinson, Brooklyn, N. Y. 1880
*Thomas Addis Emmett, New York 1884
*Isaac E. Taylor, N. Y. 1884
*D. Hayes Agnew, Philadelphia 1886
*Joseph Leidy, Philadelphia 1886
Frederick S. Dennis, New York 1893
*John H. Ripley, New York 1893
*Virgil P. Gibney, New York 1893
*William Pierson, Orange, N. J. 1894
*Abraham Jacobi, New York 1896
*Virgil M. D. Marcy, Cape May City 1896
*Samuel H. Pennington, Newark, N. J. 1897
*Alfred A. Woodhull, Princeton, N. J. 1897
*J. Leonard Corning, New York 1902
*John Allen Wyeth, New York 1903
William K. Van Reypen, U. S. N. 1903
Lawrence F. Flick, Philadelphia, Pa. 1903
S. Adolphus Knopf, New York 1906
*Albert Vander Veer, Albany, N. Y. 1907
Charles K. Mills, Philadelphia, Pa. 1917
Richard C. Cabot, Boston, Mass. 1917
George W. Crile, Cleveland, Ohio 1917
*John B. Deaver, Philadelphia 1917
*William J. Chandler, Lawtey, Florida 1923
Edward J. Ill, Newark, N. J. 1925
Joseph E. Raycroft, Trenton, N. J. 1930

THE MEDICAL SOCIETY OF NEW JERSEY

OFFICERS

President, A. Haines Lippincott ..... Camden
First Vice-President, Frederic J. Quigley .... Union City
Second Vice-President, Lancelot Ely ..... Somerville
Third Vice-President, Marcus W. Newcomb .. Brown's Mills
Secretary, J. Bennett Morrison ..... Newark
Treasurer, Elias J. Marsh ..... Paterson

TRUSTEES

Andrew F. McBride, *Chairman* (1934) ..... Paterson
H. W. Nafey, *Secretary* (1935) ..... New Brunswick
A. Haines Lippincott ..... Camden
Frederic J. Quigley ..... Union City
Lancelot Ely ..... Somerville
Marcus W. Newcomb ..... Brown's Mills
J. Bennett Morrison ..... Newark
Elias J. Marsh ..... Paterson
Walt P. Conaway (1933) ..... Atlantic City
Charles B. Smith (1933) ..... Washington
*Martin W. Reddan (1933) ..... Trenton
William G. Herrman (1933) ..... Asbury Park
James S. Green (1935) ..... Elizabeth
Blase Cole (1935) ..... Newton
R. M. A. Davis (1935) ..... Salem
Wells P. Eagleton (1934) ..... Newark
Harold B. Disbrow (1934) ..... Lakewood

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Christopher C. Beling, Newark
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... S. T. Snedecor, Hackensack
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... F. G. Scammell, Trenton
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... James Fisher, Asbury Park
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Aldrich C. Crowe, Ocean City

STANDING COMMITTEES

Committee on Scientific Work

W. Blair Stewart, *Chm.*, Atlantic City	Term expires	1933
Louis C. Lange, Weehawken	" "	1934
Ralph K. Hollinshed, Westville	" "	1935

Delegates to the American Medical Association

John F. Hagerty	Term expires	1935
B. S. Pollak	" "	1933
Walt P. Conaway	" "	1935
E. R. Mulford	" "	1933

Alternate Delegates

George H. Sexsmith	Term expires	1935
Philip Marvel	" "	1935
S. B. English	" "	1933
S. T. Quinn	" "	1933

Committee on Publication

Henry C. Barkhorn, *Chm.*, Newark	Term expires	1933
Edward J. Ill, Newark	" "	1934
Linn Emerson, Orange	" "	1935
A. Haines Lippincott		Ex-officio
J. Bennett Morrison		Ex-officio

Committee on Finance and Budget

Harry R. North, *Chm.*, Trenton	Term expires	1936
James S. Green	" "	1935
Alfred Stahl	" "	1934
Wells P. Eagleton	" "	1933
William J. Sweeney	" "	1935
William G. Herrman	" "	1937

Committee on Program and Arrangements

*Martin W. Reddan, *Chm.*, Trenton	Term expires	1934
William D. Olmstead, Atlantic City	" "	1933
William J. Carrington, Atlantic City	" "	1935
A. Haines Lippincott, Camden		Ex-officio
J. Bennett Morrison, Newark		Ex-officio

Committee on Honorary Membership

Thomas W. Harvey, *Chm.*	Term expires	1934
William G. Schauffler	" "	1935
Ephraim R. Mulford	" "	1933

Committee on Hospitals and Medical Education

Samuel A. Cosgrove, *Chm.*
William W. Brooke
Arcangelo Liva
John H. Carlisle
William J. Carrington
Charles B. Kelley
William R. Little
Royce Paddock
Louis A. Pyle
Dan S. Renner
Harry H. Satchwell
J. Vincent Smith
Edward G. Waters

Scientific Sections

Chairmen for the Annual Meeting of 1933

Section	*Chairman*
Eye, Ear, Nose, Throat	C. H. Schlichter, 556 N. Broad St., Eliz.
Pediatrics	F. C. Johnson, 51 Livingston Ave., N. Brunswick
Radiology	C. B. Kaighn, 905 Pacific Ave., Atlantic City
School Physicians	A. G. Ireland, Trenton Trust Bldg., Tren.

Committee on Welfare

Samuel G. Berkow ..... Perth Amboy
Lawrence H. Bloom ..... Phillipsburg
Richard J. Brown ..... South Orange
J. C. Clayton ..... Freehold
A. H. Coleman ..... Clinton
Joseph G. Coleman ..... Hamburg
Walt P. Conaway ..... Atlantic City
William F. Costello ..... Dover
George F. Dandois ..... Wildwood
Richard M. A. Davis ..... Salem
Lucius F. Donohoe ..... Bayonne
John F. Hagerty ..... Newark
James S. Green ..... Elizabeth
D. Leo Haggerty ..... Trenton
Francis R. Haussling ..... Newark
Charles J. Larkey ..... Bayonne
Thomas B. Lee ..... Camden
A. Haines Lippincott ..... Camden
Joseph F. Londrigan ..... Hoboken
Andrew F. McBride ..... Paterson
B. C. McMahon ..... Morristown
Josiah Meigh ..... Bernardsville
J. Bennett Morrison ..... Newark
Joseph R. Morrow ..... Oradell
Ephraim R. Mulford ..... Burlington
Harry R. North ..... Trenton
William G. Schauffler ..... Princeton
C. H. Schlichter ..... Elizabeth
Millard F. Sewall ..... Bridgeton
Elbert S. Sherman ..... Newark
George N. J. Sommer ..... Trenton
Adolph Towbin ..... Lakewood
George T. Tracy ..... Beverly
Chester I. Ulmer ..... Gibbstown

STANDING COMMITTEES—(Continued)

MEMBERS OF THE STATE SOCIETY NOMINATING COMMITTEE FOR 1933

COUNTY	DELEGATE	ALTERNATE
ATLANTIC	W. E. Darnall, 5 S. Morris Ave., A. C.	
BERGEN	A. Liva, Rutherford	
BURLINGTON	H. L. Rogers, Riverton	E. P. Darlington, New Lisbon
CAMDEN	Thomas B. Lee, 527 Penn Ave., Camden	
CAPE MAY	Clarence W. Way, Sea Isle City	
CUMBERLAND	H. G. Miller, Millville	Chas. Butcher, Heislerville
ESSEX	A. Stahl, 55 Lincoln Park, Newark	A. C. Zehnder, 188 Roseville Ave., Newark
GLOUCESTER	E. E. Downs, Woodbury	J. H. Underwood, Woodbury
HUDSON	W. J. Sweeney, Weehawken	H. Alexander, 1029 Garden St., Hoboken
HUNTERDON	S. B. English, Glen Gardner	A. H. Coleman, Clinton
MERCER	Harry R. North, 160 W. State St., Trenton	D. L. Haggerty, 227 N. Warren St., Trenton
MIDDLESEX	Frank C. Johnson, 51 Livingston Ave.,N. Br'sw'k	
MONMOUTH	W. G. Herrman, 501 Grand Ave., Asbury Park	
MORRIS	Wm. F. Costello, 55 W. Blackwell St., Dover	
OCEAN	Eugene Herbener, Lakewood	Abraham Goldstein, Lakewood
PASSAIC	John S. Yates, 414 Ellison St., Paterson	
SALEM	R. M. A. Davis, Salem	D. W. Green, Salem
SOMERSET	A. L. Stillwell, Somerville	Dan Renner, Skillman
SUSSEX	F. P. Wilbur, Franklin	F. H. Morrison, Newton
UNION	Stephen Quinn, 1143 E. Jersey St., Elizabeth	
WARREN	W. H. Varney	Herman Baldauf

SPECIAL COMMITTEES

Reference Committee on Contstitution and By-Laws

Frederic J. Quigley, *Chm.*..4622 Hudson Blvd., Union City
George H. Lathrope.....965 Broad St., Newark
J. Bennett Morrison ..... 66 Milford Ave., Newark

Public Health Committee

William G. Schauffler.....21 Morven Pl., Princeton
J. C. Shapiro.....712 Palisade Ave., Union City
Stanley H. Nichols.....Asbury Park
F. C. Johnson.....51 Livingston Ave., New Brunswick
Julius Levy Dept. of Health, Plane & William Sts., N'w'k
Allen G. Ireland.....Trenton Trust Bldg., Trenton

Committee to Study State Medicine

Francis H. Todd, *Chm.*.....Auburn St., Paterson
Henry C. Barkhorn.....45 Johnson Ave., Newark
W. Blair Stewart.....N. Carolina & Pacific Aves., A. C.
John H. Rowland.....159 New St., New Brunswick
Barclay S. Fuhrmann.....Flemington

Committee on Matters Pertaining to Workmen's Compensation Act

George N. J. Sommer, *Chm.*.....120 W. State St., Trenton
Francis R. Haussling.....661 High St., Newark
Joseph H. Londrigan..... 535 Washington St., Hoboken
I. M. Vanderhoff.....9 Clinton St., Newark
Elmer P. Weigel.....727 Park Ave., Plainfield
David A. Kraker.....31 Lincoln Park, Newark
Joseph P. Morrill .....310 Broadway, Paterson

Committee on Health, Accident, Life and Automobile Insurance

Frank W. Pinneo, *Chm.* ..... Newark
J. Finley Bell ..... Englewood
Austin H. Coleman ..... Clinton
Frederic J. Quigley ..... Union City
James S. Green ..... Elizabeth
C. I. Ulmer ..... Gibbstown
Clarence W. Way ..... Sea Isle City
Irving D. Williams ..... New York City

Committee on Maternal Welfare

Arthur W. Bingham .... 144 Harrison St., East Orange
Theodore Teimer ..... 17 Hillside Ave., Newark
George Van Voris Warner.....E. Front St., Red Bank
P. Du Bois Bunting.....712 N. Broad St., Elizabeth
John F. Condon ..... 686 Mt. Prospect Ave., Newark
Carl Ill.....188 Clinton Ave., Newark
Walter B. Mount.....11 Seymour St., Montclair

Committee on School Health to Coöperate with Dr. Ireland

George J. Holmes.....17 Elizabeth Ave., Newark
William G. Schauffler.....21 Morven Pl., Princeton
Elbert S. Sherman.....671 Broad St., Newark
William F. Costello.....Dover
H. E. Longsdorf.....Mt. Holly

SUB-COMMITTEES APPOINTED BY THE CHAIRMAN OF THE WELFARE COMMITTEE

Committee on Observation of Proposed Legislation

D. Leo Haggerty, *Chm.*.....227 N. Warren St., Trenton
Paul M. Mecray.....405 Cooper St., Camden
Harry R. North ..... 160 West State St., Trenton
F. G. Scammell.....40 S. Clinton Ave., Trenton
Joseph M. Kuder.....Mt. Holly

Committee on Expert Testimony

J. F. Londrigan, *Chm.*.....535 Washington St., Hoboken
Elbert S. Sherman.....671 Broad St., Newark
C. H. Schlichter.....556 N. Broad St., Elizabeth

Committee to Consider Narcotic Legislation

Charles H. Schlichter.....556 N. Broad St., Elizabeth
James S. Green.....463 N. Broad St., Elizabeth
J. B. Morrison.....66 Milford Ave., Newark
G. N. J. Sommer.....120 West State St., Trenton
C. I. Ulmer.....Gibbstown

Committee on "Report of Committee on Costs of Medical Care"

E. S. Sherman, *Chm.*.....671 Broad St., Newark
Joseph Londrigan.....535 Washington St., Hobokcn
John H. Rowland ..... 159 New St., New Brunswick
Joseph M. Kuder.....Mt. Holly
L. H. Bloom.....Phillipsburg
S. Rubinow.....755 High St., Newark

Committee on Veteran's Bonus and Health Legislation

Andrew F. McBride, *Chm.*.....30 Church St., Paterson
Lucius F. Donohoe.....140 W. Eighth St., Bayonne
David B. Allman.....104 St. Charles Pl., Atlantic City
J. C. Clayton.....Freehold
C. A. Brokaw.....1405 North Ave., Elizabeth

Committee to Consider Legislation Regarding Barbital and Similar Drugs

Frederic J. Quigley, *Chm.*..4622 Hudson Blvd., Union City
S. T. Quinn.....1143 E. Jersey St., Elizabeth
Francis R. Haussling.....661 High St., Newark

ANNUAL DELEGATES TO THE MEDICAL SOCIETY OF NEW JERSEY FOR 1933

ATLANTIC COUNTY

Delegates	Alternates
Scanlan, D. Ward	Walker, Levi M.
Salasin, Samuel L.	Sinkinson, Chas. D., Jr.
Harvey, Edwin H.	Mason, James H., 3rd
Carrington, Wm. J.	Fish, Clyde M.
Barbash, Samuel	Uzzell, Edward F.
Stewart, W. Blair	Stern, Samuel
Darnall, W. Edgar	Gorson, Samuel F.

BERGEN COUNTY

Morrow, J.	Sarla, M.
Liva, A.	Kimg, C.
Finke, George W.	Hitzemann, L.
Hallett, F. S.	Edwards, J. B.
Levitas, G. M.	Webb, W. D.
Payne, J.	Townsend, T. E.
Trossbach, H.	Pallen, Conde
Snedecor, S. T.	Wilson, H. B.
Vroom, William	Van Dyke, J.

BURLINGTON COUNTY

Rogers, Harry I.
Darlington, Emlem P.
Rodman, E. Warren

CAMDEN COUNTY

Hollinshed, Beulah	Schrack, Helen
MacAlister, Alex.	Pike, Charles
Hummel, E. G.	Shipman, J. S.
Raughley, W. C.	
Howard, J. E.	
Roberts, J. E.	
Lewis, T. K.	
Glover, L. H.	
Del Duca, Vincent	
Jack, W. H.	

CAPE MAY COUNTY

Way, Clarence W.
Crowe, Aldrich C.
Dandois, Geo. F.

CUMBERLAND COUNTY

Myatt, L. E.	Aitken, Frank
Miller, G. H.	Butcher, Chas.
Woodruff, Dare	Wilson, Chas.

ESSEX COUNTY

Blackbourne, Geo.	Brown, Richard J.
Crecca, Wm. D.	Cohn, Herman
Freeman, Richard D.	Fewsmith, Jos. L.
Hurff, Jos. W.	Furman, Benj. A.
Ill, Edgar A.	Harvey, Thos. W., Jr.
Orton, Henry B.	Keller, Paul
Quinby, Wm. O'G.	MacArthur, Clymont
Ranson, B. B.	Olcott, George P.
Reissman, Erwin	Schulte, Herbert A.
Rogers, Robert H.	Siegel, J. W.
Steiner, Edwin	Willan, Edward H.
Tarbell, Harold A.	Bissett, John V.
Van Ness, Roy H.	Brown, Lewis W.

ESSEX COUNTY—Continued

Delegates	Alternates
Zhender, A. C.	Carbone, F. R.
Condon, John F.	Conlon, Philip
Corwin, T. W.	Cook, Hugh F.
Dieffenbach, R. H.	Curtis, Elbert A.
Dowd, Ambrose	Echikson, Jos. I.
Griffiths, C. B.	Harden, Albert S.
Hawkes, E. Zeh.	Hughes, Lee W.
Ill, Charles I.	Ill, Herbert M.
Mitchell, A. J.	Kessler, H. H.
Snavely, E. H.	Morris, Clement
Sprague, Edward W.	Muta, S. A.
Teimer, Theodore	Smith, E. L.
Wherry, E. G.	Baldwin, S. H.
Epstein, Harry B.	Bianchi, A. R.
Fort, J. Irving	Chamberlain, A. R.
Gennell, Ernest	Comando, H. N.
Gray, John W.	Devlin, Frank
Hanan, James T.	Horsford, F. C.
Haussling, F. R.	Keller, Sidney C.
Hosp, Paul H.	Klein, E. C.
Mullin, Raymond J.	Matheke, Otto G.
Parker, John E.	Menk, Paul E.
Payne, Guy	Morgan, Browne
Pilch, Arthur C.	Mount, Walter B.
Rathgeber, Chas. F.	Richardson, Arthur
Rich, Charles	Warner, W. H. A.
Stahl, Alfred	Yaguda, Asher
Weber, Francis	
Wood, E. LeRoy	

GLOUCESTER COUNTY

Pedrick, Wm.	Ristine, E. R.
Brewer, Wm.	Ulmer, C. I.
Hollinshed, Ralph K.	Knight, I. W.

HUDSON COUNTY

Barbarito, Wm. N.	Behrens, H.
Nevin, John	Kolb, J. M.
Kelley, Chas. B.	Binder, J.
Pagliughi, J. J.	Benjamin, H.
Luippold, E. J.	Kulhmann, A.
Woodruff, S. W.	Thum, E.
Alexander, H.	Harter, L. F.
Larkey, C. J.	Mutter, A. A.
Jaffin, A. E.	
Hasking, A. P.	
Freile, William	
Frundt, O. C.	
Sweeney, W. J.	
Swiney, M. A.	
Klaus, H.	
Cassidy, J. M.	
Pollak, B. S.	
Cosgrove, S. A.	
Tidwell, H. F.	
Ballinger, R. L.	
Waters, W. E. G.	
Lange, L. E.	
Perlberg, H. J.	
Londrigan, J. F.	

HUNTERDON COUNTY

Fuhrmann, B. S.	Tompkins, G. B.
Coleman, A. H.	Gramsch, A. L.
English, S. B.	Lane, E. W.

MERCER COUNTY

Delegates	Alternates
Hutchinson, A. D.	
North, H. R.	
Vanneman, J. S.	
Ackley, D. B.	
Bellis, H. D.	
Seeley, H. R.	
Swern, Nathan	
Adams, O. F.	
Haggerty, D. L.	
McGuire, J. J.	

MIDDLESEX COUNTY

Spencer, A.
Mann, J. J.
Meinzer, M. S.
Gutman, B.
Weber, J. F.
Johnson, F. C.
Mark, Jos.

MONMOUTH COUNTY

Fairbanks, W. H.	Herrman, Wm. G.
Nichols, Stanley	Featherston, D. F.
	Maher, J. E.

MORRIS COUNTY

Kraus, F. L.	Plume, Clarence A.
McMahon, B. C.	Thomas, T. S.

OCEAN COUNTY

Bunnell, Fred
Disbrow, V. M.
Herbener, E.

PASSAIC COUNTY

Cantrell, W. C.	Tomauro, J. S.
Delario, A. J.	MacGregor, A. W.
Ginsburg, Samuel	Markel, A.

PASSAIC COUNTY—Continued

Delegates	Alternates
Harreys, Chas. W.	Phelps, J. E.
Levinsohn, S.	Polowe, D.
Thorne, Wm. P.	
Yates, John S.	
Carlisle, J.	
Gillson, John T.	
Todd, F. H.	
Bergin, John B.	
McCoy, John C.	
Lucas, H. H.	
Spickers, Wm.	
Tuers, Ed.	
Ryan, John	

SALEM COUNTY

James, H. W.
Dunn, John L.
Green, D. W.

SOMERSET COUNTY

Renner, D. S.	Sferra, A. F.
Stillwell, A.	
Hegeman, R. F.	
Cooper, J. H.	
Lawton, A. A.	

SUSSEX COUNTY

Wilbur, F. P.
Morrison, F. H.

UNION COUNTY

Quinn, Stephen T.
Harrison, J. B.
Schlichter, C. H.
Prout, T. B.
Stein, Isidore
Brokaw, C. A.
Stein, Emil
Runnells, John
Bowles, Harry M.
Hubbard, H. V.
Currie, Norman
Johnson, H. F.
Orton, Geo.

WARREN COUNTY

Smith, G. B.
Cummins, G. W.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in November.

Bergen County.—Meets on second Tuesday each month, except July and August. Annual Meeting in January.

Burlington County.—Meets second Wednesday afternoon of January, March, May, September and November. Annual Meeting in November.

Camden County.—Meets first Tuesday in each month October to May inclusive, with an outing on second Tuesday in June. Annual Meeting in October.

Cape May County.—Meets on first Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets on the second Tueslay of January, April, July and October. Annual Meeting in October.

Essex County—Annual Meeting is the first Thursday in October. Other meetings on the second Thursday of each month, November to May, inclusive, on call of the President.

Gloucester County.—Regular meetings on the third Thursday of each month, October to June, inclusive. Annual Meeting in November. Annual Social Session in September.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. Annual Meeting in October.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8.30 p. m., in the Carteret Club at Trenton. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on the third Wednesday afternoon of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the last Wednesday in each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

Morris County.—Meets on the second Tuesday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

Ocean County.—Meets in May and November as called by the Secretary. Annual Meeting in November.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social Meeting in May.

Somerset County.—Meets on the second Thursday afternoon in February April, June, October and December. Annual Meeting in October.

Sussex County—Annual Meeting on the second Tuesday in September; other meetings bimonthly, September to May inclusive.

Union County—Meets on the second Wednesday of January, April, July and October. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October; the last named being the Annual Meeting.

MEMBERSHIP OF COUNTY MEDICAL SOCIETY

Comprising the

MEDICAL SOCIETY OF NEW JERSEY

1933

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets Friday of each month. Annual meeting in December.

President

Shivers, Charles H. deT., Atlantic City

Vice-President

Allman, David A., Atlantic City

Secretary and Treasurer

Irvin, John S., Atlantic City

Reporter

Walker, Levi M., Atlantic City

Historian

Harley, H. L., Atlantic City

Censors

Davidson, Harold S., Atlantic City
Ivers, Homer I., Atlantic City
Quinn, Norman J., Atlantic City

Allman, David B., 104 St. Charles pl., Atl. City
Andrews, Clarence L., 1616 Pacific av., Atl. City
Axilrod, Maurice H., 2620 Pacific av., Atl. City
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 117 S. Illinois av., Atl. City
Beir, I. R., Harverford Apts., Atlantic City
Berner, David, 2817 Pacific av., Atlantic City
Blampin, Wineford A., Galen Hall, Atlantic City
Boysen, T. H., 100 Philadelphia st., Egg Harbor
Britton, Roland L., 336 N. Main st., Mays Landing
Carrington, Wm. J., 905 Pacific av., Atlantic City
Charlton, C. Coulter, 124 S. Illinois av., Atl. City
Chew, Elisha C., 603 Pacific av., Atlantic City
Clark, S. Worth, 152 S. North Carolina av., Atl. C'y
Conaway, Walt P., 1723 Pacific av., Atlantic City
Cooney, Charles J., 121 S. Illinois av., Atlantic City
Corson, Filbert R., 101 S. Indiana av., Atl. City
Coward, Edwin H., 1423 Pacific av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Cuskaden, A. D., 5902 Ventnor av., Ventnor
Dalton, S. Eugene, 1616 Pacific av., Atlantic City
Darnall, Wm. Edgar, 5 S. Morris av., Atlantic City
Davidson, Harold S., 1616 Pacific av., Atlantic City
Davis, W. Cole, 124 S. Illinois av., Atlantic City
deHellebranth R. T., 104 S. Fr'nkf't av., Ventnor
Doherty, Wm. John, 201 N. Main st., Pleasantville
Dunlap, Thomas G., 47 S. Virginia av., Atl. City
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Fischer John S., 20 S. Jackson av., Ventnor
Fish Clyde M., 7 W. Washington av., Pleasantville
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtle, 227 Philadelphia st., Egg Harbor
Garrabrant, Clarence, 19 N. Penn av., Atl. City
Gordon, Carl, 222 Caspian av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pl'santville
Guion, Edward, P. O. Box 418, Atlantic City
Haley, Mark J., 8106 Ventnor av., Margate
Harley Halvor L., 101 S. Indiana av., Atlantic City
Harvey, Edwin H., 20 N. Florida av., Atlantic City
Holt, Edward Z., Children's Seashore Home, Atl.C.
Hudson, W. J., 39 W. Wash'gton av., Pleasantville
Hyman, Chas., 1616 Pacific av., Atlantic City
Ireland, Milton S., 23 S. California av., Atl. City
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobsen, J. Jos., 1616 Pacific av., Atlantic City
James, Henry C., Mays Landing
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kaighn, Chas. B., 905 Pacific av., Atlantic City
Kilduffe, Robert A., 5003 Atlantic av., Ventnor
Krechmer, Abraham, 521 Pacific av., Atlantic City
Leonard Isaac E., 2842 Atlantic av., Atlantic City
Mackler, Louis, 705 Pacific av., Atlantic City
Madden, Leland S. Verona av., Pleasantville
Magill, Marcus, 4116 Ventnor av., Atlantic City
Marcus, Joseph H., 1148 Fifth av., N. Y. C., N.Y
Marshall, Jos. C., 1517 Pacific av, Atlantic City
Martin, Wm., 117 S. Illinois av. Atlantic City
Mason, James H., 3rd, 1616 Pacific av., Atl. City
Massey, John F., 20 Newport av., Ventnor
McGeehan Stanley M., Ryanhurst Apts., Atl. City
Merendino, Anthony G., 2707 Pacific av., Atl. City
MeVay James C., 2907 Pacific av., Atlantic City
Muellerschoen, Geo. J., 220 S. 16th st., Phila., Pa
Nickman, Harrison, 101 S. Indiana av., Atl. City
Olmstead, Wm. D., 1710 Pacific av., Atlantic City
Pennington, Geo. P., 12 S. Chelsea av., Atl. City
Pennington, John, 101 S. Indiana av., Atl. City
Poland, Geo. A., 25 E. Washington av., Pl'santville
Poland, Joseph, 1904 Pacific av., Atlantic City
Quinn, Norman J., 3303 Pacific av., Atlantic City
Richardson, Jas. J., Hotel Claridge, Atlantic City
Rosenblatt, Sidney, 1920 Pacific av., Atlantic City
Salasin, Samuel L., 511 Pacific av., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, Geo., 2900 Pacific av., Atlantic City
Scott, Karl M., 1616 Pacific av., Atlantic City
Senseman, Theodore, 3600 Pacific av., Atl. City
Shenfeld, Isaac, 501 Pacific av., Atlantic City
Shimer, A. Burton, 606 Pacific av., Atlantic City
Shivers, Charles H., 121 S. Illinois av., Atl. City
Shivers, C. H. deT., 121 S. Illinois av., Atl. City
Siegel, A. E., 3831 Atlantic av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City
Smith, Andrew M., 344 Philadelphia st., Egg H'rb'r
Stalberg, Samuel, 1109 Pacific av., Atlantic City
Stamps, G. Ruffin, 214 E. Verona av., Pleasantv'le
Stern, Samuel, 2815 Pacific av., Atlantic City
Stevenson, A. M., 6622 Ventnor av., Ventnor
Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Stewart, W. Blair, N. Carolina & Pacific avs., At.C'y
Subin, Harry, 1616 Pacific av., Atlantic City
Timberlake, Baxter H., 1616 Pacific av., Atl. City
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Walker, Levi M., 151 S. Penn. av., Atlantic City
Wescott, Wm. C., Delaware & Pacific avs., Atl.C'y
Westney, Alfred W., 3005 Pacific av., Atlantic City
Whims, Clarence B., 7117 Ventnor av., Ventnor C.
White, R. Rostin, N. Y. & Sunny avs., Somers Pt.
Williams, R. A., Swarthmore & Atl. avs., V'tnor C.

ATLANTIC COUNTY—Continued

Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City
Reynolds, Walter, Atlantic City
Souder, Lewis R., 5 S. Victoria av., Ventnor

Non-Member Associate Members

Barab, Barney B., Ph. G., D. D. S., Atlantic City
Brown, Charles, 4407 Ventnor av., Atlantic City
Kohn, Wm. B., 101 S. Indiana av., Atlantic City
Mally, Manuel J., D. D. S., Atlantic City
Singer, Dudley G., Ph. G., Va. & Pacific avs.,At.C.
Steigerwald, C. S., D.D.S., Jackson av., Ventnor
Von Deilen, Arthur W., D.D.S.,1616 Pacific av.,A.C.

Honorary Members

Lawrence, Henry R., Atlantic City
Gehring, Gustave P., San Diego, Calif.
Reik, Henry O., Vermont Apts., Atlantic City

Resigned

Bateman, S. E.
Kremens, M. B.

Transferred

Richardson, Jas., J., received from California
Siegel, Alvin E., received from Pennsylvania
Davus, W. Price, to New York

Number of members and basis of representation, 103.

*Deceased.

100 per cent paid up Feb. 5, 1933.

BERGEN COUNTY (2)

Society organized February 28, 1854. Meets second Tuesday in each month. Annual meeting second Tuesday in January.

President

Alexander, Samuel, Park Ridge

Vice-President

Liva, A., Rutherford

Secretary

Snedecor, Spencer T., Hackensack

Treasurer

Sarla, M., Hackensack

Reporter

Littwin, Charles, Englewood

Censors

The President, Secretary and Treasurer

Adams, Flora, Hackensack
Alexander, Samuel, Park Ridge
Allen, W. B., Englewood
Anderson, R. M., Hackensack
Angelillis, P., Hackensack
Appold, George D., Bergenfield
*Armstrong, Samuel E., Rutherford
Baketel, S. H., Jersey City
Balze, H. R., Leonia
Barnes, William J., Englewood
Bell, J. Finley, Englewood
Berke, R. N., Hackensack
Beyer, W. Jr., 38 Grand av., Englewood
Bickner, A. W., Jr., Rutherford
Blauvelt, Grace B., Ridgewood
Bleasby, C., Garfield
Blenkle, V. A., Teaneck
Bookstaver, B. F., Teaneck
Bono, J., Northvale
Bosch, C. C. F., Dumont
Bosch, T., Midland Park
Bregman, Alexander, Edgewater
Brennan, A. T. V., Tenafly
Brown, J. L., Grantwood
Buckley, P. T., Bogota
Burbank, H. E., Lyndhurst
Burnham, L., Tenafly
Burns, G. C. H., Tenafly
Busicco, P. S., Englewood
Byer, C. W., Rutherford
Caldroney, T. L., Ridgefield Park
Clarke, Edward W., West Englewood
Cloud, A. W., Englewood
Cochrane, Cleland D., Closter
*Cone, Ralph, Westwood
Connor, Clarence A., Fort Lee
Cooper,H. M., Ridge rd. & Passaic av., Rutherford
Corn, David, Ridgefield Park
Crandall, John K., Fort Lee
Cropsey, Charles D., Rutherford
Curtis, Donald, Hackensack
D'Agostin, Henry, Cliffside
Dayton, S. T., Englewood
Decker, J. G., Hasbrouck Heights
Dezer, Chas. N., Jr., Englewood
Dickson, J. D., Bogota
Dilger, F. G., Cliffside
*Edwards, G. c/P.S. Clarke 255 Ryerson st.,Br'k'n
Edwards, James B., Leonia
Essertier, Edward P., Hackensack
Farmer, Vincent, Hackensack
Farr, W. J., Teaneck
Fielding, William M., Allendale
Finke, George W., Hackensack
Finke, John H. D., Hackensack
Fitzhugh, W. F., Ridgefield Park
Fliegel, William, Maywood
Fox, James W., Hillside
Franklin, S. I., Englewood
Freeland, Frank, Hackensack
Garrett, Harry S., Park Ridge
Gersham, J. G., Dumont
Gilady, Ralph, Hackensack
Gillett, H. E., Ramsey
Gnasso, E. R., Fort Lee
Goldberg, David, Westwood
Greenfield, A. W., Hackensack
Greenfield, W. J., Hackensack
Grimes, Jesse R., Dumont
Groff, P. A., Little Ferry
Hallet, Frederick S., Hackensack
Harney, J. N., Teaneck
Harryman, William K., Hackensack
Helff, J. R., Teaneck
Heller, G. H., Englewood
Hitzeman, L. A., 30 E. Passaic st., Maywood
Hoheb, A. S., Rutherford
Hoheb, K. R., Rutherford
Horowitz, H. J., Morsemere
Hubbard, S. T., Hackensack
Huff, Edmund N., Englewood
Hull, D. B., Ridgewood
Irwin, J. H., Englewood

BERGEN COUNTY—Continued

James, W. L., Englewood
Johnson, G. L., Englewood
Johnston, S. F., Rochelle Park
Johnston, R. O., Harrington Park
Jordan, W. L., Englewood
Jukofsky, I. D., Ridgefield Park
Kastler, F., Rutherford
Keir, Floyd E., Englewood
Kennedy, P. A., Englewood
Kenney, C. B., Fairlawn
Kenyon, H. M., Bergenfield
King, Chester A., Oradell
Kingslow, G. L., Hackensack
Knapp, Richard E., Hackensack
Knox, C. A., Ridgefield Park
Knowles, G. M., Ridgefield Park
Knox, Harriet L., Hackensack
Kraissl, C., Englewood
Leddecke, Rowland E., E. Rutherford
Levitas, Geo. M., Westwood
Lewis, Alice B., Saddle River
Littwin, Charles, Englewood
Liva, Arcangelo, 5 Pangborn Pl., Hackensack
Liva, P. F., Lyndhurst
Lynch, M. M., Hackensack
Lyons, S. R., Englewood
Macauley, F. A., Tenafly
Mackellar, James M., Tenafly
Markley, L. A., Teaneck
Mader, A. I., Hackensack
McCormack, F. C., Englewood
McDannald, William S., Tenafly
McDede, E. H., Lyndhurst
McFeeley, P. R., Bogota
McLeod, H. J., Englewood
Mears, W. G., Englewood
Meyer, Edward H., Mahwah
Meyer, H. N., 141 Central Ave., Maywood
Morrow, Joseph R., Isolation Hospital, Oradell
Mosher, H. L., Lyndhurst
Muller, F. L., Carlstadt
Mulligan, L. A., Leonia
Netz, L. W., Hackensack
Nicols, F. I., Hackensack
Niles, Frank Lee, Hackensack
O'Brien, Paul, East Rutherford
Payne, Joseph, Midland Park
Pedevill, J., Palisade Park
Perham, Roy G., Hasbrouck Heights
Phillips, Walter, Englewood
Pitkin, George P., Bergenfield
Prather, J. W., Dumont
Proctor, James Wm., Englewood
Protzman, T. B., Englewood
Prout, Wm. B., West Englewood
Pullen, G. F., Leonia
Reich, S. B., Oradell
Reid, Erwin W., Garfield
Richardson, Charles A., Closter
Richie, E. W., Hackensack
Rowe, J. A., Ridgefield
Ruch, Louis, Englewood
Rube, J. H., Ridgewood
Ruch, Valentine, Englewood
Ryley, H. W., East Rutherford
Sandler, M., Fort Lee
Sarla, Michael, Hackensack
Sawyer, E. E. Hackensack
Schmidt, Walter W., Cliffside Park
Scullion, Arthur, Cliffside
Sealey, H. J., Dumont
Seiler, B., Cliffside Park
Seymour, E. T., Tenafly
Skvarla, J. A., Wallington
Snedecor, S. T., 50 Anderson St., Hackensack
Stedman, H. E., Englewood
Spiegelglass, A. B., Hackensack
Stevenson, George S., Hasbrouck Heights
Taylor, H. W., Englewood
Teeter, John N., Englewood
Tennis, E. N., Tenafly
Tether, Russell K., Closter
Tidwell, G. W., 7 Union Blvd., Wallington
Toal, Joseph, Ridgefield
Townsend, T. E., Westwood
Trossbach, Herman, Bogota
Tyson, Francis B., Leonia
Vanderbeek, S. W., Englewood
Vandersluis, H., Park Ridge
Van Dyke, Joseph S., Palisade Park
Vita, F. T., Grantwood
Vroom, W. L., Ridgewood
Walsh, T. M., Hasbrouck Heights
Ward, Alfred W., Demarest
Ward, G., Harold, Englewood
Warren, Charles B., Bergenfield
Webb, Wilson D., Hackensack
White, R. E., Glen Rock
Whitman, L. B., Bergenfield
Whittaker. N. McL., Hackensack
Wilson, H. B., Hackensack
Williams, W. C., Rutherford
Willoughby, W. F., Englewood
Winter, G., Teaneck
Witkoff, B., Woodridge
Wolowitz, Harry B., Hackensack
Worcester, George F., Englewood
Wry, Orlin V., E. Rutherford
Wurts, Margaret M., Englewood

Honorary Members

Bell, J., Finley, Englewood
Pratt, John E., Dumont
Riordon, J., Rutherford
Swayze, A. A., Hackensack
Clock, Ralph C., Pearl River

Transfers

Lewis Greenberg to New York
Franklin G. Young to Union County
Sheridan Baketel from Kings County

Associate Members of Other Societies

Denison, W. C., Ridgewood
Liddy, Frank P., Mahwah
Sava, F., Hackensack
Twinem, Francis P., Hackensack

Associate or Junior Members

Dunn, Theodore, 326 Park St., Hackensack
Friedman, A. I., 145 Marshall Ave., Little Ferry
Legato, Samuel F., 402 Anderson Ave., Cliffside
Morrison, B. G., 500 Marlboro Rd., Woodridge
Morrn, H. C., Dumont
McLane, A. Donald, 155 Eagle St., Englewood
Yates, Palmer S., 328 Undercliff Ave., Edgewater
Patti, F. A., 304 Broad Ave., Leonia
Rucker, Wm. C., Hackensack Hos., Hackensack
Van Winkle, Chas. I., 192 Home Ave., Rutherford

Number of members and basis of representation, Feb. 1, 1933, 191.

100 per cent paid up Feb. 1, 1933.

*Deceased

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Meets second Wednesday in January, April, June and October. Annual meeting in October.

President

Conroy, John S., Burlington

Vice-President

Davis, John M., Burlington

Secretary and Treasurer

Tracy, George T., Beverly

Reporter

Kuder, Joseph M., Mt. Holly

Censors

Anderson, R. D., Burlington
Dubell, J. E., Columbus
Mulford, E. R., Burlington

Anderson, Richard D., Burlington
Bauer, Harry W., Palmyra
Busansky, Samuel T., New Lisbon
Conroy, John S., Burlington
Curtis, Howard C., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, Vincentown
Davis, Jacob M., Burlington
Downs, Roscius I., Riverside
Dubell, John E., Columbus
Fahrenbruch, F. D., Mt. Holly
Geary, Russell D., Riverside
Haines, Edgar J., Medford
Haldeman, Robert E., Mt. Holly
Hartman, Luther, Maple Shade
Hollingshead, Lyman B., Pemberton
Hogan, Carlton P., Burlington
Hornberger, J. Howard, Roebling
Hunter, Edward R., Delanco
Imhoff, R. E., Moorestown
Kuder, Joseph M., Mt. Holly
Le Favor, Dean H., Palmyra
Longsdorf, Harold E., Mt. Holly
Love, Elizabeth F., Moorestown
Marcy, Alexander, Jr., Riverton
Marks, S. J., Bordentown
McDonnell, G. E., Mt. Holly
Mendenhall, Clinton D., Bordentown
Metzer, Emma P. W., Riverside
Meyer, Eugene A., Moorestown
Mills, Charles S., Riverton
Mulford, Ephraim R., Burlington
Muldoon, Edward J., Florence
Newcomb, Marcus W., Brown's Mills
Remer, Daniel F., Mt. Holly
Rodman, E. Warren, Beverly
Rogers, Harry L., Riverton
Schisler, Milton M., Florence
Scott, Parry M., Beverly
Shipps, Hammel P., Delanco
Small, E. Lester, Medford
Stokes, Joseph, Moorestown
Stokes, Samuel Emblen, Moorestown
Summey, Thomas J., Moorestown
Sutherland, W. S., Mt. Holly
Thorne, Nathan, Moorestown
Tracy, George T., Beverly
Ulmer, David H. B., Moorestown
Viteri, Louis, Mt. Holly
Wagner, J. G., Riverside
Wilkinson, Geo. H., Moorestown
Zwick, W. Walter, Riverside

Transfers

Corpening, Flave H., to Camden County
Resinger, P. B, to Mercer County

Honorary Members

Stoddard, Francis J., Riverton

Non-Resident Associate Members

Borzell, F. F., Philadelphia, Pa.

Number of members and basis of representation, 52.

100 per cent paid up February 1, 1933.

*Deceased.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets second Tuesday of every month. Annual meeting in October.

President

Davis, Albert B., Camden

Vice-President

Lee, Thomas B., Camden

Secretary

Gamon, Robert S., Camden

Treasurer

Lewis, T. K., Camden

Reporter

Del Duca, Vincent, Camden

Historian

Bentley, David F., Jr., Camden

Censors

Barrett, W. J., Camden
Hummel, E. G., Camden
Pratt, William H., 516 Cooper st., Camden
Rogers, E. B., Collingswood
Van Sciver, J. E. L., Camden

Bailey, Wilson G., 512 Broadway, Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, K. B., Kaighn & Princess avs., Camden
Barrett, Wesley J., 517 Cooper st., Camden
*Bardsley, Chester A., Park av., Laurel Springs
Barnshaw, Harold M., 2626 Federal st., Camden
Becker, Fred C., 620 Benson st., Camden
Beideman, Caspar M., 5 W. Maple av., Merch'tv'le
Bentley, David F., Jr., 403 Cooper st., Camden
Brennan, Chas. L. S., 19 S. Broadway, Gloucester
Brennan, John P., 306 Cooper st., Camden

CAMDEN COUNTY—Continued

Brewer, David R., 536 Market st., Gloucester
Browning, Wm. J., 134 N. Centre st., M'ch'tv'le
Browning, W. Kempton, 120 N.C'ntre st., M'ch'tv'le
Bush, Ralph K., 131 E. Park ave., Merchantville
Butler, Samuel S., 1100 Kaign av., Camden
Buzby, B. Franklin, 414 Cooper st., Camden
Capauno, Giacinto, 829 So. 4th st., Camden
Carlander, C. R., 1972 Browning rd., Merch'vtville
Casselman, Arthur J., 301 N. 2nd st., Camden
Ciliberti, Frank J., 5th & Pine sts., Camden
Clark, Ernest B., 209 Haddon av., Westmont
Clement, Levina B., 124 Kings Hwy., W. H'd'f'd
Collier, Martin H., Camden Co. Hosp., Lakeland
Conoly, Lacy N., 601 Walnut st., Camden
Corpening, Flave H., Park av., Laurel Springs
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 725 Collings av., W. Cillingsw'd
Crowley, Joseph W., 4005 Westville av., Camden
Davis, Albert B., 511 Cooper st., Camden
Davis, J., Stannard, Haddonfield
Davenport, I. P., 270 Washington terr., Audubon
Day, Grafton E., Frazier & N.J. avs., Collingsw'd
Deibert, Irwin E., 618 Benson av., Camden
Del Duca, Vincent, 406 Cooper st., Camden
Donoho, A. P., Walnut & Centre, Merchantville
Driscoll, Chas. D., 213 Clements Br. rd., Bar'gton
Dublin, George T., 211 N. 5th st., Camden
Eaton, Arthur T., 201 4th av., Haddon Heights
Ellis, Alexander, 513 Broadway, Camden
Elwell, Alfred M., 407 Cooper st., Camden
Ewing, Leslie H., Broad st., Berlin
Evans, Winborne D., 2704 Westville av., Camden
Farrell, Edgar A., 100 Kings H'wy W., H'd'nf'ld
Filkins, Cedric E., 418 W. Horse Pike, Audubon
Fisher, Stella C., 4401 Westfield av., Camden
Gamon, Robert S., 558 Newton av., Camden
German, Geo. B., 429 Cooper st., Camden
Glover, Lawrence L, 232 King's Hwy., Haddonf'ld
Goldstein, Hyman I., 1425 Broadway, Camden
Hadley, C. F., 201 W. Maple av., Merchantville
Haines, Mabel S., 600 White Horse Pike, Audubon
Haines, Wm. H., 217 Lafayette av., Audubon
Hays, Roy G., 567 Haddon av., Collingswood
Hessert, Edmund C., Haddon & Col. avs., C'l'gsw'd
Hirst, E. Reed, 586 Federal st., Camden
Hirst, Levi B., 586 Federal st., Camden
Hollinshed, Beulah S., 600 Benson st., Camden
Horner-Roger, Clara L., 721 Cooper st., Camden
Howard, J. Edgar, 67 King's H'way, W. H'donf'ld
Hughes, Thos. E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 135 N. Centre st., M'ch'tville
Hutcheson, Chas. R., 517 Cooper st., Camden
Jack, H. Wesley, 920 Haddon av., Collingswood
Jackson, Chas. H., 1250 Pk. Boulevard, Camden
Jarrett, Harry, 925 Broadway, Camden
Johnson, Chas. H., 632 Benson st., Camden
Kain, Wm. W., Cape May C't House, R.F.D.No.1
Kain, Thomas M., 403 Cooper st,, Camden
Kinney, A. G., 249 Woodlawn ter., Collingswood
Kline, Oram R., 414 Cooper st., Camden
Kutner, Chas., 1005 S. 5th st., Camden
Larossa, Ernest A., 701 Cooper st., Camden
Lee, Thomas B., 622 Cooper st., Camden
Lewandowski, S. S., 1450 Mt. Ephraim av., Camd'n
Lewis, Thos. K., 47 So. 27th st., Camden
Lippincott, A. Haines, 406 Cooper st., Camden
Lovett, Jos. C., Municipal Hospital, Camden
Lyon, Leslie C., P. O. Box 63, Magnolia
McCarthy, Arthur M., 2772 Federal st., Camden
McCollum, A, S., 213 Clements Br. rd., B'r'gt'n
McConaghy, T. P., S.W.Cor. 10 & Cooper sts., C'm'n
McDermott, Vincent, 511 State st., Camden
Macalister, Alexander, 626 Federal st., Camden
MacAlpine, K. B., 533 Monmouth st. Gl't'r City
Madden, Theop. W., 16 Frazier av., Collingswood
Mahaffey, Jesse L., 542 Cooper st., Camden
Maldeis, A. M. K., 117 North 6th st., Camden
Marcarian, Henry B., 904 Cooper st., Camden
Mecray, Paul M., 405 Cooper st., Camden
Mengel, Willard G., 400 Penn av., Camden
Meyer, George P., 410 Haddon av., Camden
Moore, Wm. G,. 1576 Mt. Ephraim av., Camden
Nowrey, Jos. E., Jr., 431 Vine st., Camden
Ondovchak, M. F., 1494 Mt. Ephraim av., Camden
Osmun, Milton M., 611 Broadway, Camden
Palm, Howard F., 614 N. 2nd st., Camden
Phillips, Claude B., 891 Haddon av., Collingswood
Pike, Charles E., 411 Newton st., Oaklyn
Pinsky, M. Meyer, 944 S. 5th st., Camden
*Powell, Wm. R., 702 Market st., Camden
Pratt, William H., 516 Cooper st., Camden
Principato, Roberto, 402 Walnut st., Camden
Raughley, Wm. C., Taunton av., Berlin
Rhone, David S., 1202 Haddon av., Camden
Richardson, Emma M., 577 Steven st., Camden
Roberts, Jos. E., Jr., 403 Cooper st., Camden
Rogers, Edw. B., 814 Haddon av., Collingswood
Ross, Alex. S., 542 Cooper st., Camden
Russell, Edward W., 801 Cooper st., Camden
Ruttenberg, Max, 210 State st., Camden
Saunders, O. W., 1700 Broadway, Camden
Schall, Elmer R., 7th & Elm sts., Camden
Scheffler, W. A. H., 511 Cooper st., Camden
Schellenger, E. A. Y., 429 Cooper st., Camden
Shipman, James S., 542 Cooper st., Camden
Schrack, Helen F., 216 N. 5th st., Camden
Schwartz, Henry C., Atco, N. J.
Schruggs, W. J., 3005 Kearsage rd., Fairview, Cam.
Shafer, Alfred H., 405 Cooper st., Camden
Shafer, Fred'k Wm., 634 Penn av., Camden
Sharp, Jennie M., 726 Cooper st., Camden
Sharp, R. L., 726 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingw'd
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shope, E. P., 956 Newton av., Camden
Shull, E. C., 150 N. 32nd st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Smith, James D., 701 N. 6th st., Camden
*Smith, Walter H., 100 Kings Hwy., Haddonfield
Stone, A. L., 2838 Berkley st., Camden
Summerill, Garnett, 330 Cooper st., Camden
Van Sciver, John E. L., 106 Broadway, Camden
Ward, Lettie A., 325 Cooper st., Camden
Weiman, M. L., 803 Station av., Haddon Heights
West, Gordon F., 527 Penn st., Camden
Wiant, Herman E., 120 Windsor av., Haddonfield
Wilson, L. R., 3320 Federal st., Camden
Wilson, I. E., 110 Chapel av., Merchantville
Wroblewski, B., 1166 Thurman st., Camden

Honorary Members

Nicholson, J. L., Haddonfield
Leavitt, John F., Camden

Received on Transfer

Corpening, F. H.

Resigned

Shahinian, S. M.
Dunham, H. B.

Number of members and basis of representation, 139.

100 per cent paid up Feb. 1933.

*Deceased.

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Meets first Tuesday in April and October. Annual meeting in October.

President

Corson, Allen, Ocean City

Vice-President

Robbins, Warren D., Cape May City

Secretary and Reporter

Way, Eugene, Sea Island City

Treasurer

Tomlin, H. Hurlburt, Wildwood

Censors

Gandy, C. M., Ocean View
Haines, W. P., Ocean City
Hughes, Frank R., Cape May

Brooks, George M., Cape May Court House
Corson, Allen, Ocean City
Crowe, Aldrich C., Ocean City
Cryder, Millard, Cape May Court House
Dandois, George F., Wildwood
Darby, A. Eugene, Ocean City
Gandy, Charles M., Ocean View
Hornstine, H. H., Wildwood
Hughes, Frank R., Cape May
Keck, William F., Cape May
Mace, Margaret, North Wildwood
Pettit, Herschel, Ocean City
Robbins, Warren D., Cape May City
Steele, William, Beesley's Point
Tomlin, H. Hurlburt, Wildwood
Townsend, John, Ocean City
Way, Clarence W., Sea Isle City
Way, Eugene, Sea Isle City
Way, Julius, Cape May Court House
Whiticar, John H., Ocean City
Ziegler, Oscar, Wildwood

Non Resident Honorary Members

Gandy, Charles L., U. S. A.
Gordon, Alfred, Philadelphia, Pa.
Ingram, J. H., China
Reik, Henry O., Atlantic City

Number of members and basis of representation, 21.

100 per cent paid up February 1, 1933.

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets second Tuesday of January, April, July and October. Annual meeting in October.

President

Winslow, John H., Vineland

Vice-President

Simkins, Ray, Bridgeton

Secretary

Wilson, H. H., Bridgeton

Reporter

Corson, Elton S., Bridgeton

Censors

Gray, Charles H., Vineland
Branin, Howard, Millville
Sewall, Millard F., Bridgeton

Bacon, Mary, Bridgeton
Baker, Hugh W., Vineland
Bellak, Ellis R., Leesburg
Bennett, Samuel D., Millville
Bostwick, Delazon S., Bridgeton
Branin, Howard, Millville
Butcher, Charles, Heisleville
Clippinger, R. D., Vineland
Corson, Elton S., Bridgeton
Cornwell, Alfred W., Bridgeton
Cunningham, Charles, Jr., Vineland
Davies, George A., Elmer
Day, Samuel Thomas, Port Norris
Elmer, Matthew K., Bridgeton
*Fritts, Herbert H., Shiloh
Garrison, Walter Sherman, Cedarville
Gray, Charles M., Vineland
Harris, Allen, Greenwich
Kauffman, Louis J., Millville
Knowles, James S., Millville
Lloyd, Reba (Kumpf), Bridgeton
Loder, Horace B, Bridgeton
Loper, John G., Bridgeton
Lore, Harry E., Bridgeton
Lummis, C. Percy, Bridgeton
Lyon, Earl C., Bridgeton
Mayhew, Charles H., Millville
Miller, H. Garrett, Millville
Myatt, Leslie E., Bridgeton
Neal, Charles B., Millville
Oliver, David H., Bridgeton
Ramsey, F., Muriel, Millville
Reeves, J. Franklin, Bridgeton
Sewall, Millard F., Bridgeton
Sharp, Charles E., Port Norris
Sheppard, Frank R., Millville
Simpkins, Raymond, Bridgeton
*Smith, Thomas J., Bridgeton
Thalheimer, E. J., Vineland
Thomas, George N., Vineland
Van Deusen, Edwin H., Vineland
Wainwright, F. P., Bridgeton
Walker, Ada Harris, Vineland
Walker, H. Burton, Vineland
Ware, Fred V., Millville
*Webster, D. King, Leesburg
Weithaase, Helen E., Vineland
Whaland, Berta, Bridgeton
Wilson, Charles W., Vineland
Wilson, Herbert H., Bridgeton
Winslow, John H., Vineland
Woodruff, Dare, Vineland

Non-Resident Associate Members

Ashton, W. E., 2011 Walnut st., Philadelphia, Pa.
Barton, J. M., 1314 Spruce st., Philadelphia, Pa.
*Deland, Judson, 317 S. 18th st., Philadelphia, Pa.
De Costa, J. C., 2045 Walnut st., Philadelphia, Pa.
*Hare, H. A., 1801 Spruce st., Philadelphia, Pa.
Hirst, B. C., 1821 Spruce st., Philadelphia, Pa.
Keen, W. W., 1729 Chestnut st., Philadelphia, Pa.
Noble, Charles P., 1509 Locust st., Phila., Pa.
Reisman, David, 162 Spruce st., Philadelphia, Pa.

Number of members and basis of representation, 49.

100 per cent paid up February 1st, 1933.

*Deceased.

ESSEX COUNTY (7)

Society organized June 18, 1816. Meets second Thursday, at call of Council, from October to May. Annual meeting in October.

President

Areson, Wm. H., Upper Montclair

Vice-President

Sprague, Edward W., Newark

Secretary

Pinneo, Frank W., Newark

Treasurer

Rogers, Robert H., Newark

Reporter

Wood, E. LeRoy, Newark

Councilors

Baker, C. Fred'k
Condon, John F.
Ill, Edgar A.
Kraker, David A.
Moore, John D.
Ranson, B. B., Jr.
Stahl, Alfred
VanNess, H. Roy
The Ex-Presidents (ex-officio)

Abrams, A. B., 668 Clinton av., Newark
Adams, John K., 3 Prospect st., E. Orange
Adelman, Benj. B., 190 Clinton av., Newark
Albano, Joseph, 535 N. 7th st., Newark
Albee, Geo. C., 219 S. Orange av., S. Orange
Alexander, Wallace G., 48 Webster pl., Orange
Allan, James S., 49 Prospect st., E. Orange
Allen, G. Herbert, 181 Roseville av., Newark
Allen, W. J., 144 Harrison st., E. Orange
Alling, Frederick A., 15 Washington st., Newark
Ambrose, Anthony, 71 Congress st., Newark
Antonius, N. A., 27 W. Market st., Newark
Anuario, Chas. B., 283 S. Centre st., Orange
Areson, Wm. H., 153 B'vue av., Upper Montclair
Asher, Maurice, 186 Clinton av., Newark
Aszody, Paul, 340 Waverly av., Newark
Avidan, Maurice S., 30 Stratford pl., Newark
Bachmann, Wm., 87 Hillcrest ter., East Orange
Bagg, Linus W., 31 Lincoln Park, Newark
Baird, T. M., 124 Grand pl., Arlington
Baker, Charles F., 198 Clinton av., Newark
Baldwin, Samuel H., 626 Clinton av., Newark
Banks, Winfred D., 6 N. Munn av., East Orange
Barkhorn, Charles W., 223 Roseville av., Newark
Barkhorn, Henry C., 45 Johnson av., Newark
Barrett, Jos. F., 230 Parker av., Maplewood
Bass, Rose D., 222 Lyons av., Newark
Baum, Felix, 31 Lincoln Park, Newark
Baum, Samuel, 10 Osborne ter., Newark
Becker, Fred W., 14 Clinton pl., Newark
Becket, George C., 350 Springdale av., E. Orange
Beling, Chris. C., 109 Clinton av., Newark
Bell, Thomas, 340 Belmont av., Newark
Benedict, A. C., 121 Irvington av., South Orange
Bengelsdorf, A., 29 Clinton pl., Newark
Bennett, W. F., Essex Co. Sanatorium, Verona
Beradinelli, C. G., 92 Eighth av., Newark
Berg, S., 530 Central av., Newark
Berger, W. A., 268 No. 7th st., Newark
Bergman, M. W., 825 So. 10th st., Newark
Berman, Robert H., 286 Roseville av., Newark
Beyer, O. J., 42 Laurel av., Irvington
Bianchi, Angelo R., 104 7th av., Newark
Bien, Frank A., 999 Clinton av., Irvington
Bigelow, N. S., 117 Irvington av., South Orange
Bingham, Arthur W., 144 Harrison st., E. Orange
Birdsall, Clarence, 3 Small av., Caldwell
Bissett, John V., 29 Hawthorne av., E. Orange
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 25 S. Munn av., E. Orange
Bleick, Theo. E., 61 Van Ness pl., Newark
Bleick, William D., 583 Prospect av., Maplewood
Block, Marcus T., 177 Bloomfield av., Newark
Boker, Emory, 544 Springfield av., Newark
Bostwick, Wallace R., 56 Church st., Montclair
Boyle, Thos. P., 2 Gouverneur st., Newark
Brackett, Elizabeth R., 349 Franklin av., Nutley
Bradford, Stella S., 16 Seymour st., Montclair
Bradshaw, John H., 27 High st., Orange
Brakeley, Elizabeth, 21 Trinity pl., Montclair
Braun, Gus A., 391 Bergen st., Newark
Brien, Wm. M., 449 Main st., Orange
Briggs, H., 207 Harrison st., E. Orange
Brim, Anne J. S., 83 Lincoln Park, Newark
Broadnax, Mary E., 83 Lincoln Park, Newark
Brodkin, Eva T., 365 Osborne terrace, Newark
Brodkin, H. A., 365 Osborne ter., Newark
Brooke, C. R., 1136 Broad st., Newark
Brotman, Morton, M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown E. V., 585 Kearny av., Arlington
Brown, Lewis W., 15 Fulton st., Newark
Brown, Richard J., 105 Ridgewood rd., So. Or.
*Bruington, S. S., 115 Spruce st., Newark
Buermann, William, 9 Lincoln Park, Newark
Buckley, J. L., 684 Franklin av., Nutley
Bull, W. J., 92 Heller Parkway, Newark
Bull, Louis M., 92 Heller Parkway, Newark
Bumsted, Clarence, 235 Grafton av., Newark
Bunn, F. C., 30 Hillyer st., Orange
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burns, Edward L., 269 Broad st., Newark
Burpeau, Wm. P., 17 Wayne av., East Orange
Bush, Archer C., 40 Union av., Montclair
Busch, Herman 38 Johnson av., Newark
Butler, Eustace C., 249 Bloomfield av., Caldwell
Buvinger, Chas. W., 50 Washington st., E. Orange
Cacciarelli, Robt. A., 517 Roseville av., Newark
Cahill, L. A., 353 Lafayette st., Newark
Caldwell, J A., 45 S. Mountain av., Montclair
Camche, L. J., 458 Hawthorne av., Newark
Cameron, Edwin A., 186 S. Burnett st., E. Orange
Campbell, H. B., 21 Court st., Newark
*Campbell, Wellington, Short Hills
Campbell, Wm., 144 Harrison st., East Orange
Carbone, Francis R., 157 Hunterdon st., Newark
Cardwell, E. P., 15 Fulton st., Newark
Carman, Fletcher F., 31 Lincoln Park, Newark
Caruso, Rocco J., 222 Mt. Prospect av., Newark
Casale, John B., 496 Highland av., Newark
Cater, Douglas A., 55 Harrison st., East Orange
Cerone, Daniel M., 89 Mt. Prospect av., Newark
Chamberlain, Aims R., 30 Lenox pl., Maplewood
Chapman, R. W., 835 Bergen st., Newark
Chattin, J. F., 671 Broad st., Newark
Cherashore, H., 363 Centre st., Nutley
Chiger, Alexander S., 621 High st., Newark
Chmelnik, A. G., 299 Clinton av., Newark
Clark, J. Henry, 108 Orange road, Montclair
Clarken, Jos. A., 43 Lincoln Park, Newark
Coburn, John W., 25 S. Munn av., East Orange

ESSEX COUNTY—Continued

Coe, Richard, 156 Clinton av., Newark
Coffin, Henry, 433 Mt. Prospect av., Newark
Coghlan, Jasper, 17 Academy st., Newark
Cohen, M., 106 Valley rd., Montclair
Cohen, Meyer J., 32 Runyon st., Newark
Cohen, Sidney L., 20 Avon av., Newark
Cohn, G. M., 748 S. 10th st., Newark
Cohn, Herman, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Colmer, Meyer J., 407 Lyons av., Newark
Colsh, LeRoy L. 612 Ridgewood rd., Maplewood
Comando, Harry N., 31 Lincoln Park, Newark
Condon, John F., 686 Mt. Prospect av., Newark
Conlon, Philip, 25 James st., Newark
Connamacher, H. S., 671 Springfield av., Newark
Connolly, John J., 212 Market st., Newark
Connolly, Richard N., City Hospital, Newark
Cook, H. F., 31 Lincoln Park, Newark
Cooke, Wm. H., 303 Main st., East Orange
Cooperman, Wm., 647 Market st., Newark
Corwin, Theo. W., 671 Broad st., Newark
Corrigan, Geo. F., 344 Lafayette st., Newark
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 594 Kearny av., Arlington
Cox, William W., 27 S. Fullerton av., Montclair
Cox, John Calvin, 55 Woodland rd., Maplewood
Crane, Chas. G., 78 Farley av., Newark
Crankshaw, C. W., Pru. Ins. Co., Newark
Craster, Chas. V., 381 Parker st., Newark
Crawford, G. U., 28 Carnegie av., East Orange
Crecca, Wm. D., 111 Park av., Newark
Crossfield, H. C., 491 S. Orange av., South Orange
Crystell, E. H., Hillside av., Nutley
Curtis, Elbert A., 65 Central av., Newark
Dane, Chas., 61 Scotland rd., South Orange
Dane, John, 61 Scotland rd., South Orange
Danzis, Max, 31 Lincoln Park, Newark
Darden, Walter T., 149 W. Kinney st., Newark
Davenport, Peter B., 764 S. Orange av., Newark
Davidson, Henry A., 31 Lincoln Park, Newark
DeFronzo, Morando, 180 Fairmount av., Newark
Del Deo, Nicholas V., 47½ State st., Newark
Del Guercio, O., 342 Clifton av., Newark
Demarest, L. M., 228 S. Orange av., South Orange
De Michele, Roland V., 456 Roseville av., Newark
Denes, O. J., 402 Centre av., Nutley
Deriveaux, John A., 103 Clinton av., Newark
De Vausney, Winfield S., 50 James st., Newark
De Vincentis, Henry, 285 Henry st., Orange
Devlin, Frank, 617 Broadway, Newark
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Rich'd H., 570 Mt. Prosp.av.,Newark
Dinge, Ferdinand Chas., 31 Lincoln Park, Newark
Dodd, Raymond C., 18 Snowden pl., Glen Ridge
Dodd, Edward, L., 151 Forest st., Belleville
Donahue, Wm. J., 173 Roseville av., Newark
Donchi, S. M., 346 Belmont av., Newark
Donnelly, Robt. J., 208 Market st., Newark
Doremus, Widmer E., 31 Lincoln Park, Newark
Dorn. Elliot I., 267 Vassar av., Newark
Dowd, Ambrose F., 239 Broadway, Newark
Dreskin, J. L., 172 Lyons av., Newark
Dragonetti, E. N., 177 Clifton av., Newark
DuBois, M. G., 769 High st., Newark
Dulin, Everett K., 144 Harrison av., E. Orange
*Duncker, Fred'k W., 136 Monmouth st., Newark
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, S. W., 344 High st., Newark
Echikson, Joseph I., 845 S. 12th st., Newark
Edelen, James J., 280 S. Clinton st., E. Orange
Eigen, Louis A., 190 Clinton av., Newark
Ein, Wm. B., 31 Lincoln Park, Newark
Emerson, Linn, 310 Main st., Orange
Emmer, S. Wolfe, 234 Clinton av., Newark
English, James R., 51 Cypress st., Newark
Epler, Don A., 45 Hillside av., Newark
Epstein, Henry B., 31 Lincoln Park, Newark
Erler, Eugene W., 119 N. 5th st., Newark
Etheridge, Charles E., 376 Prospect st., E. Orange
Evans, David P., 144 Harrison st., E. Orange
Evans, Charles H., 144 Harrison av., E. Orange
Ewing, Harvey M., 31 Lincoln Park, Newark
Fager. Rudolph O., 98 Broad st., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol. J., 31 Lincoln Park, Newark
Farden, Jos. L., 342 Roseville av., Newark
Farr, Irving L., 214 Walnut st., Montclair
Fattel, Henry C., 142 Chadwick av., Newark
Fasano, G., 194 S. 7th st., Newark
Faughnan, Rose, 97 High st., Passaic
Fechner, Julius, 138 W. Kinney st., Newark
Federman, P. H., 220 Fairmount av., Newark
Fendrick, Edward, 138 Park pl., Irvington
Ferguson, W. E., Newark Conv. Hosp., Maplew'd
Fern, S. S., 122 Elizabeth av., Newark
Fewsmith, Jos. L., 120 Second av., Newark
Fine, Moses J., 175 Clinton av., Newark
Finesilver, Edward M., 31 Lincoln Park, Newark
Fink, Irving E., 129 Lyons av., Newark
Finkel, Joshua, 368 Clinton av., Newark
Finkler, Rita S., 99 Lyons av., Newark
Fischer, E. J., 29 Ashwood terrace, W. Orange
Fischman, H. H., 34 Sterling st., Newark
Finkelstein, A. S., 174 Johnson av., Newark
Fitzpatrick, Edward F., 574 Warren st., Newark
Flower, M. A., 39 Lincoln Park, Newark
Flynn, E. A., 161 Washington av., Belleville
Forsythe, Kenneth C., 530 Summer av., Newark
Fort, J. Irving, 306 Roseville av., Newark
Forte, Frank S., 456 Roseville av., Newark
Foster, Herbert W., 2 Erwin Park, Montclair
Foster, W. S, 233 Mt. Prospect av., Newark
Fowler, Royal H., 744 Broad st., Newark
Frederick, Gus H., 349 Camden st., Newark
Freeman, George C., 1 Lenox pl., Maplewood
Freeman, Richard D., 103 Scotland rd., S. Orange
Friedman, M., Beth Israel Hosp., Lyons av. New'k
Freinkel, Jacob, 2 Hillside av., Newark
Froelich, J. C., 74 Ingraham pl., Newark
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 190 Johnson av., Newark
Ganley, Arthur J., 390 Park av., East Orange
Ganot, F. I., 639 Ridge st., Newark
Gantz, O. E., 215 N. Grove st., East Orange
Gardam, J. W., 16 Longfellow av., Newark
Gauch, Wm., 177 Ellwood av., Newark
Gelber, L. J., 41 Lincoln av., Newark
George, M. E. W., 805 Broadway, Newark
Gershenfeld, David B., 20 Hillside av., Newark
Gifford, W. Royal, 247 Park av., East Orange
*Gilbert, Harry J., 588 Broadway, Newark
Gilman, Malcolm B., 59 Seeley av., Arlington
Glass, William H., 144 Harrison st., E. Orange
Glass, Oscar, 638 High st., Newark
Godfrey, Allan O., 220 Roseville av., Newark
Goeller, J. D., 1165 W. Clinton av., Irvington
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel M., 353 Wash av., Belleville
Goffman, Emanuel, 81 Valley rd., Montclair
Goldstein, Henry Z., 190 Clinton av., Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goldstein, W. H., 632 Belgrove dr., Arlington
Goodfellow, G. P., 161 Prospect st., E. Orange

ESSEX COUNTY—Continued

Goodwin, Wm. M., 75 Congress st., Newark
Gordon, A. J., 273 Roseville av., Newark
Grady, Wm. F., 42 N. Fullerton av., Montclair
Grant, William F., 162 Roseville av., Newark
Gray, John W., 142 Clinton av., Newark
Green, William H., 230 Bank st., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bern'd H., 691 Clinton av., Newark
Gregorius, Ralph F., 120 Irvington av., S. Or.
Gregory, Mildred G., 21 Roseville av., Newark
Greifinger, Marcus H., 22 Vassar av., Newark
Griffith, Roy, 909 Broad st., Newark
Griffiths, Chauncey B., 31 Lincoln Park, Newark
Guthrie, W. G., 300 Summer av., Newark
Gutkowski, W. T., 104 Grove terrace, Irvington
Hagerty, John F., 212 W. Market st., Newark
Hagney, Fred W., 669 Elizabeth av., Newark
Hahn, Katherine B., 272 Thornden st., So. Orange
Hahn, William, 272 Thornden st., So. Orange
Halprin, Harry, 8 Washburn pl., Caldwell
Hanan, Jas. T., 11 The Crescent, Montclair
Harden, Albert S., 540 Warren st., Newark
Harhen, Geo. E., 22 Brookside av., Caldwell
Hart, H. M., 300 Mt. Prospect av., Newark
Harvey, Thos. W., 59 Main st., Orange
Harvey, Thos. W., Jr., 59 Main st., Orange
Hasney, Fredrick A., 292 Main st., W. Orange
Hauck, Lydia B., 644 Stuyvesant av., Irvington
Hauck, Wm. H., 644 Stuyvesant av., Irvington
Haussling, Francis R., 661 High st., Newark
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Zeh, 84 Washington st., Newark
Heath, Louanna, 20 Fairmount av., Newark
Heineken, T. S., 17 Park pl., Bloomfield
Heller, Nathan B., 31 Lincoln Park, Newark
Henle, C. B., 671 Springfield av., Newark
Herman, John H., 197 S. Centre st., Orange
Herndon, Lewis S., 33 Johnson av., Newark
Herold, Harvey T., 850 S. 13th st., Newark
Hewson, James S., 163 Myrtle av., Millburn
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Hicks, William H., 46 Milford av., Newark
Hill, Robert H., 332 Park av., Newark
Hilton, C. O., 598 N. 5th st., Newark
Hobart, Richard T., 191 Bellev'le av., U. Montcl'r
Hoeler, Wm., F., 808 S. 11th st., Newark
Holden, Edgar, Jr., 217 Broadway, Newark
Holland, Geo. A., 364 Clinton av., Newark
Holler, Henry G., 234 Montclair av., Newark
Holmes, Geo. J., 17 Elizabeth av., Newark
Horn, Max, 80 Lyons av., Newark
Horsford, Fred C., 305 Broadway, Newark
Hosp, Paul H., 842 S. 12th st., Newark
Houck, W. J., 207 Mt. Prospect av., Newark
Hubbard, Fayette E., 65 Church st., Montclair
Hubbard, Robert Y., 58 Myrtle av., Irvington
Huber, Wm. H., 15 Salem st, Newark
Huberman, John, 853 So. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Hulett, Albert G., 20 Hawthorne av., E. Orange
Humphries, Robert E., 637 Central av, E. Orange
Hurff, Jos. W., 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Ignatoff, M. L., 493 Central av., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Charles L., 188 Clinton av., Newark
Ill, Edgar A., 1002 Broad st, Newark
Ill, Edmund W., 188 Clinton av., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Inge, Theo. R., 336 Halsted st., East Orange
Irwin, Jas. R., 330 Washington av., Belleville
Jackson, Albert F., 225 Hillside av., Nutley
Jackson, E. C., 98 Washington st., E. Orange
James, Bart M., 31 Lincoln Park, Newark
Janifer, Clarence S., 208 Parker st., Newark
Jedel, Meyer, 125 Fourth st., Newark
Jessurun, S. H., 613 High st., Newark
Jones, E. C., 75 Midland av., Montclair
Jonitz, Robert, 157 S. Grove st., E. Orange
Judge, John F., 1009 So. Orange av., Newark
Just, Francis, 564 High st., Newark
Kalb, S. W., 416 Clinton pl., Newark
Kahrs, Grace M., 375 Mt. Prospect av., Newark
Kalter, George E., 640 Prospect st., Maplewood
*Kaufman, Ignatz, Newark
Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, M. J., 103 Lyons av., Newark
Kaufhold, Frank, 41 Leslie st. Newark
Kavanaugh, D. E., 252 Washington av., Belleville
Kearney, Edward P., 26 Forest st., Montclair
Keim, Wm. F., 25 Roseville av., Newark
Keller, Sidney C., 31 Lincoln Park, Newark
Kenney, J. A., 132 W. Kinney st., Newark
Kern, E. Clarence, 45 Park st., Montclair
Kerns, Francis J., 556 Warren st., Newark
Kessler, H. H., 31 Lincoln Park, Newark
Kessler, Henry B., 666 Clinton av., Newark
Kiley, J. E., 31 Lincoln Park, Newark
Kirkby, Cyril S., 98 Broad st., Bloomfield
Kirkman, Leroy G,. 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Edward C., Jr., 209 Littleton av., Newark
Klein, Ignatz, 471 Springfield av., Newark
Kleinman, Maurice, 2 Farley av., Newark
Klenk, J. P., 328 Belleville av., Bloomfield
Kolodin, A., 147 Franklin st., Bloomfield
Kraker, David A., 31 Lincoln Park, Newark
Kraemer, Manfred, 186 Clinton av., Newark
Krichbaum, Carroll E., 63 Myrtle av., Montclair
Krone, W. F., 31 Lincoln Park, Newark
Kummel, M., 315 Central av., E. Newark
Lafferty, Elton B., 149 Harrison st., E. Orange
Lane, Austin W., 98 Prospect st., East Orange
Lane, Frank B., 53 Woodland av., East Orange
Lawrence, Minnie J., 83 Second av., Newark
LeBel, Louis J. B., 165 Grant av., Nutley
Lee, Stephen, G., 55 Halsted st., East Orange
Leff, Chas. O., 83 Farley av., Newark
*Lehlbach, C. F., U.S.Sea S'rv'e,157 Cedar st.,N.Y.
Leonardis, Jas. V., 94 Jefferson st., Newark
Levin, M. L., 209 Avon av., Newark
Levin, Joseph, 831 S. 13th st., Newark
Levinson, L. J., 190 Clinton av., Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Julius, 66 Baldwin av., Newark
Lewis, Geo. R., 458 Washington av., Belleville
Leyenberger, S. B. W., 310 Mt. Prospect av., Nwk
Livingston, J., 71 Baldwin av., Newark
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 So. 17th st., Newark
Loeser, Lewis Henry, 31 Lincoln Park, Newark
Long, Herbert W., 102 Jefferson st., Newark
Lottridge, Dorothy, 43 S. Maple av., E Orange
Lowenstein, H. A., 96 Milford av., Newark
Lowitz, Otto, 78 Clinton av., Newark
Lowrey, Jas. H., 79 Congress st., Newark
Lowy, Otto, 190 Clinton av., Newark
Luban, Benjamin, 730 High st., Newark
Lundblad, Walt. E., 75 Prospect st., E. Orange
Luonogo, F., 212 So. Centre st., Orange
Lynch, A. E. O., 257 Orange rd., Montclair
Lyon, Archibald, 115 Ridge rd., Arlington
Lyons, James V., 333 Park av., Orange

ESSEX COUNTY—Continued

Maas, M. A., 329 Clinton av., Newark
Mabey, J. Corwin, 242 Claremont av., Montclair
MacArthur, Clymont, 219 Roseville av., Newark
Macdonald, W. S., 56 Church st., Montclair
Maciejewski, A. S., 212 Van Buren st., Newark
Mac Pherson, Elwood H., 12 Rawley pl., Millburn
Malavazos, Antonio, 635 High st., Newark
Maliniak, Jacques W., 31 Lincoln Park, Newark
Mamlet, Alfred M., 16 Johnson av., Newark
Mancusi-Ungaro, E., 270 Mt. Prospect av., N'w'k
Mancusi-Ungaro, L., 156 Mt. Prospect av., N'w'k
Mahood, H. L., 86 Durand rd., Maplewood
Mangelsdorf, A. F., 575 Belgrove dr., Arlington
Marcus, Alexander, 466 Ferry st., Newark
Marks, Edward G. 655 Kearny av., Arlington
Marquis, Dean W., 132 N. Arlington av., E. Orange
Marquis, W. James, 198 Clinton av., Newark
Martin, Wm. P., 25 Holland rd., South Orange
*Martine, F. L., 182 Roseville av., Newark
Martinetti, Carlo D., 311 Central av., Orange
Martland, Harrison S., 180 Clinton av., Newark
Matheke, O. G., 328 Sussex av., Newark
Matthews, H. E., 504 Hillside av., Orange
Matthews, W. F., 11 Seymour av., Montclair
May, Ernst A., 965 Broad st., Newark
McArthur, Chas., 5 Elm st., S. Orange
McBride, Hesser G., 1072 S. Orange av., Newark
McCabe, Thos. S., 913 Broad st., Newark
McCauley, Francis J., 31 Lincoln Park, Newark
McCormick, Jas. E., 322 Clinton av., Newark
McCoullough, W. A., Essex Co. Hosp., Cedar Gr.
McCroskery, Jas. H., 396 N. Arlington av., E. Or.
McEwen, Floy, 299 Broadway, Newark
McKim, William F., 1044 S. Orange av., Newark
McLellan, Geo. A., 19 Hawthorne av., E. Orange
McVay, Edward A., 234 Lafayette st., Newark
Medd, John C., 25 Curtis pl., Maplewood
Meehan, Martin M., 201 Joralemon st., Belleville
Meeker, Frank B., 355 Clifton av., Newark
Meeker, Irving A., 581 Valley rd., U. Montclair
Mellen, S. H., 863 Mt. Prospect av., Newark
Mendelsohn, Abraham, 68 Treacy av., Newark
Menk, Paul E., 31 Lincoln park, Newark
Merselis, John G., 110 Irvington av., S. Orange
Meurlin, Alfred, 158 Harrison st., E. Orange
Miller, I. Irwin, 193 Richelieu ter.. Newark
Miller, Jos. A., 364 Prospect st., South Orange
Minard, E. L., 140 4th av., East Orange
Minier, Carl L, 171 Ellery st., Newark
Minningham, Wm. D., 18 Hedden ter., Newark
Minnefor, C. A., 126 Carolina av., Newark
Mishell, Daniel R., 730 Prospect st., Maplewood
Mitchell, August J., 59 South st., Newark
Mockridge, Oscar A., 8 S. Mountain av., Montcl'r
Moore, John D., 6 Washington av., Bloomfield
Morgan, Browne, 260 Liberty st., Bloomfield
Morris, Clement, 513 Broadway, Newark
Morrison, Caldwell, 379 7th av., Newark
Morrison, J. Bennett, 66 Milford av., Newark
Motzenbecker, Wm., 16 Milford av., Newark
Motzenbecker, P. F., 31 Lincoln Park, Newark
Moulton, Chas. D., 122 Park av., East Orange
Mount, W. B., 21 Plymouth, Montclair
Mullin, Raymond J., 857 S. 11th st., Newark
Mullins, R. L., 144 Harrison st., East Orange
Murray, Harold A., 624 Mt. Prospect av., New'k
Muta, Samuel A., 47 Park av., West Orange
Nappi, P. E., 254 Clifton av., Newark
Nash, Albert B., 10 South 13th st., Newark
Nash, Alexander E, 20 Forest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nataro, Joseph, 172 Littleton av., Newark
Neare, Clifford B., 2 Hawthorne av., E. Orange
*Newman, Emanuel D., 81 New st., Newark
Newman, Grace T., 339 Grove st., Montclair
Neves, Charles S., 281 Park st., Montclair
Noll, Louis, 1044 Clinton av., Irvington
Nyiri, William, 30 Van Ness pl., Newark
Obuchowski, Henry T., 86 Belmont av., Newark
O'Connor, D. F., 671 Broad st., Newark
O'Connor, M. J., 8 Harrison pl., Irvington
O'Crowley, Clarence R., 31 Lincoln Park, New'k
O'Neil, Chas. L., 11 N. 7th st., Newark
Oleynick, S., 107 Clinton av., Newark
Olini, Joseph J., 30 West Market st., Newark
Openchowski, M., 52 Jones st., Newark
Opdyke, C. P., 10 Summit rd., Verona
Opdyke, Gordon McC., 10 Summit rd., Verona
Orloff, Samuel, 97 Lyons av., Newark
Orton, Henry B., 24 Commerce st., Newark
Ost, Henry B., 1109-A Broad st., Newark
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 28 Winans st., E. Orange
Palmer, H. S., 257 Mulberry st., Newark
Panitch, Wm., 352 Belmont av., Newark
Pannullo, John N., 266 Van Buren st., Newark
Parent, Sol., 924 So. 20th st., Newark
Parisi, Anthony, 150 Hunterdon st., Newark
Parker, John E., 385 Park av., Orange
Parsonnet, Eugene V., 31 Lincoln Park, Newark
Pascall, Thomas M., 197 Lincoln av., Newark
Paul, G. A., 765 Lyons av., Irvington
Payne, Guy, Overbrook Hospital, Cedar Grove
Peer, Lyndon A., 965 Broad st., Newark
Pendexter, Sid. E., 11 S. Arlington av., E.Orange
Pennington, A. W., 111 Raab av., Bloomfield
Pennington, G. P., 161 Prospect st., E. Orange
Petry, William, 109 Treacy av., Newark
Phelan, Edward D., 18 South st., Newark
Philhower, Geo. B., 281 Grant av., Nutley
Phillips, A. A., 68 West Market st., Newark
Pilch, Arthur C., 1 Willard av., Bloomfield
Pinneo, Frank W., 439 Mt. Prospect av., Newark
Pizzi, Francis W., 205 Park av., Orange
Plant, J. S., 467 High st., Newark
Plante, Amos A., 228 Dunnell rd., Maplewood
Polevski, J., 682 High st., Newark
Polow, Bejamin, 318 Hawthorne av., Newark
Pomeranz, R., 31 Lincoln Park, Newark
Potter, Raymond T., 86 Harrison st., E. Orange
Potter, Robert C., 25 Fulton st., Newark
Preston, Perry B., 12 Palm st., Newark
Price, Nathaniel G., 31 Lincoln Park, Newark
Pringle, F. A., 192 Claremont av., Montclair
Proctor, Jesse, 15 No. 13th st., Newark
Pudney, W. R., 11 Seymour st., Montclair
Quinby, Wm. O'Gorman, 14 James st., Newark
Rado, William, 190 Clinton av., Newark
Rados, Andrew, 299 Clinton av., Newark
Ragoff, George A., 291 Osborne ter., Newark
Ramos, Nicholas J., 188 Market st., Newark
Randall, Chas. H., 50 Third av., Newark
Ranson, Bris. B., J., 601 Ridgew'd av., Maplew'd
Rathgeber, Chas F., 18 William st., E. Orange
Rathgeber, Wm. M., 249 Roseville av., Newark
Ravitz, S. F., 1113 Broad st., Newark
Rawitz, Sidney B., 31 Lincoln Park, Newark
Reich, A. L., 83 Lyons av., Newark
Reilly, John V., 472 Sanford av., Newark
Reinfeld, A. G., 354 Clinton av., Newark
Reissman, E., 31 Lincoln Park, Newark
Reitter, G. S., 144 Harrison av., E. Orange
Renzuli, Francesco, 228 S. 7th st., Newark
RePass, Paul E., 42 Washington st., E. Orange
Rettig, I. L., 36 Milford av., Newark

ESSEX COUNTY—Continued

Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Harry H., 32 Broad st., Newark
Richardson, Arthur, 60 Orange rd., Montclair
Ricketts, Henry E., 31 Lincoln Park, Newark
Rigg, S. B., 506 Ridgewood av., Glen Ridge
Riggins, Edwin N., 161 No. Arlington av., E. Or.
Ripley, Edward W., 7 Trinity pl., Montclair
Rizzolo, Edward M., 250 Mt. Prospect av., New'k
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Robbins, Eugene, 909 Broad st., Newark
Roberts, D. C., 55 Randolph pl., So. Orange
Roberts, W. A., 9 Forest av., Caldwell
Robie, T. R., 144 Harrison st., E. Orange
Robins, David, 94 Hawthorne av., Newark
Robinson. L. H., 31 Lincoln Park, Newark
Roeber, Wm. J., 21 Nesbit pl., Irvington
Rogers, Harry, 144 Harrison st., E. Orange
Rogers, Richard M., 1 Wallace st., Newark
Rogers, Robert H., 49 9th av., Newark
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenstein, S. L., 557 Clinton av., Newark
Roth, Oswald H., 210 Littleton av., Newark
Rothenberg, Samuel, 1 Hillside av., Newark
Rothhouse, Burnet, 19 Lincoln Park, Newark
Rothseid Abraham, 29 Scheerer av., Newark
Rubin, A. A., 379 Washington av., Belleville
Rubinow Saul M., 755 High st., Newark
Rumage, Wm. T., 44 Walnut st., Newark
Runyan, Wm. J., 106 Broad st., Bloomfield
Russell, L. C., 192 Clinton av., Newark
Salsberg, Ralph H., 325 Peshine av., Newark
Saslow, Benj., 680 Clinton av., Newark
Satchwell, H. H., 640 Stuyvesant av., Irvington
Sbarra, F., 233 Sixth av., Newark
Schaaf, Edward O., 217 So, Orange av., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaefer, Engene P., 12 Harrison pl., Irvington
Schaffer, Nathan, 94 So. Munn av., E. Orange
Schectman, Vera, 385 Osborne ter., Newark
Scher, Maurice A., 141 Lyons av., Newark
Schiller, Nicholas, 9 Pierce st., Newark
Schimmelpfenning, R. D., 258 Claremont av.,Mtl.
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Louis, 874 So. 13th st., Newark
Schramm, Joseph A., 23 Darcy st., Newark
Schreck, Harry, 139 Roseville av., Newark
Schulsinger, S., 48 Walnut st., Newark
Schulte, H. A., 701 Clinton av., Newark
*Schwarz, Emanuel. 561 High st., Newark
Scott, R. Hunter, 205 Roseville av., Newark
Scranton, Chas. W., 31 Washington st., E. Or.
Scudder, F. D., 63 S. Fullerton av., Montclair
Seidler, William F., 29 Rossmore pl., Belleville
Seidler, V. B, 16 Plymouth st., Monclair
Seidman E,. A., 580 High st., Newark
Seidman, Marcus, 580 High st., Newark
Seifert, Edwin A., 247 Claremont av., Montclair
Sellers, Robert R., 19 Chestnut st., Newark
Shannon, J. B., 56 Church st., Montclair
Shannon, Lardner M., 66 S. Fullerton av.,M'tcl'r
Shapiro, Louis, 242 Broad st., Newark
Shaul, F. G., 10 Washington st., Bloomfield
Sherman, Allton L, 26 Northfield av., W. Orange
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 131 Renner av., Newark
Siegel, J. W, 96 S. 10th st., Newark
Silver, H. B., 190 Clinton av., Newark
Silverstein, J M., 73 Main st., Millburn
Silverstein, Benj. J., 32 Hillside av., Newark
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, Geo. F., 541 Page st., Lyndhurst
Simon, Ludwig, 201 Ferry st., Newark
Singer, Max, 147 Johnson av., Newark
Skwirsky, Joseph, 170 Hawthorne av., Newark
Smalley, Sara D., 530 Clifton av., Newark
Smalzried, E. W., 167 N. Grove st., E. Orange
Smith, Byron J., 104 Parker av., Maplewood
Smith, E. L., Soho Hospital, Belleville
Smith, G. H., 534 Central av., East Orange
Smith, H. G., Cedar Grove
Smith, Harold W., 179 Clinton av., Orange
Smith, J. J., 325 13th av,, Newark
Smith, L. H., 32 Washington st., East Orange
Smith, T. A., Short Hills
Snavely, Earl H., City Hospital, Newark
Sobin, Julius, 24 Waverly av., Newark
Solk, Arthur S., 595 S. 13th st., Newark
Somers, Fred L., 144 Harrison av., Orange
Spallone, Jos. C., 123 Mt. Prospect av., Newark
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 34 Lyons av., Newark
Stahl, Alfred, 55 Lincoln Park, Newark
Stahl, Charles, 659 Sanford av., Newark
Steiner, Edwin, 19 Lincoln Park, Newark
Stevens, J. Thompson, 55 Park st., Montclair
Stevens, Merton H., 144 Harrison st., E. Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stokes, Earl B., 49 Prospect st., East Orange
Straub, Herbert H., 242 Springdale av., E. Or.
Sutton, Jos. G., Essex County Hosp., Cedar Gr.
Swain, Richard D., 211 Roseville av., Newark
Symes, Earl H., 161 Kearny av., Kearny
Synnott, Martin, J., 63 S. Fullerton av., Montcl'r
Szerlip, L., 31 Lincoln Park, Newark
Talbot, Herbert S., 144 Harrison st., E. Orange
Tarbell, Harold, 11 Pennington st., Newark
Teeter, Charles E., 418 Orange st., Newark
Teimer, Theodore, 17 Hillside av., Newark
Terriberry. W. K., 15 Washington st., Newark
Thomas, J. H., Jr, 270 Lenox av., S. Orange
Thompson, Arthur F., 157 Harrison st., E. Orange
Thompson, Austin B., 479 Highland av., Orange
Thompson, C. S., Fair Oaks Sanitorium ,Summit
*Thompson, D. C., 98 Broad st., Bloomfield
Tildon, John W., 54 N. Clinton st., E. Orange
Tirrell, C. M., 36 Spruce st., Newark
Titman, Russell E., 275 Dodd st., East Orange
Tobey, F. J., 11 Hazelwood av., Newark
Tomassi, Chas. F., 173 Lafayette st., Newark
Tomec, Richard F., 55 S. Park st., Montclair
Toye, John E., 590 Kearny av., Arlington
Trainor, James H, 40 Johnson av., Newark
Turi, A., 57 Garside st., Newark
Turner, C. F., Grove & Cambr. sts., Montclair
Tutchulte, E., 111 Mt. Pleasant av., Newark
Twitchell, A. B., 162 S. Orange av., S. Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 174 Fleming av., Newark
Vail, Herbert B., 301 Washington av., Belleville
Vanderhoff, Irving M., 9 Clinton st., Newark
Van Der Veer, H. G., 295 Montgomery st., Bl'mfi'd
Van Emburg, Geo. H., 575 Belgrove dr., Arl'gt'n
Van Geison, Edward J., 17 Park pl., Bloomfield
Vannatta, Geo. W., 224 N. Park st., East Orange
Van Ness, H. Roy, 218 Mt. Prospect av., Newark
Verbeck, George B., 26 Washburn pl., Caldwell
VonHofe, Fred'k H., 255 Conway st., E. Orange
Voorhees, Florence E, 83 Lincoln Park, Newark
Vreeland, Ralph D., 333 Lyons av., Newark
Wakeley, W. E., 521 Main st., E. Orange

ESSEX COUNTY—Continued

Wakeley, William A., 120 Main st., Orange
Wallhauser, Henry J. F., 31 Lincoln Park, New'k
Walton, R. W., 48 N. Fullerton av., Montclair
*Waite, Geo. N., High st., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, Wm. R., 112 Chancellor av., Newark
Warner, Wm. H. A., 444 Central av., E. Orange
Weber, Francis C., 286 Mt. Prospect av., Newark
Webner, C. Fred., 71 Lincoln Park, Newark
Weinberg, Maurice M., 377 Osborne ter., New'k
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, M. W., 659 Chancellor av., Irvington
Weisman, Jos. C., 99 Elm st., W. Orange
*Weiss, Lazare, 404 Bergen st., Newark
Weiss, Selma, 2 Stratford pl., Newark
Weiss, Selma, 2 Stratford pl., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wendel, Aug. V., 205 Littleton av., Newark
Weston, C. S., 27 Woodland av., Glen Ridge
Whelan, E. P., Mountain av., W. Orange
Wheeler, W. K., 31 Lincoln Park, Newark
Wherry, Elmer G., 323 Clinton av., Newark
White, Robert R., 177 S. Burnet st., E. Orange
*Whitehorne, Henry B., 32 Grove av., Verona
Wilkes, Arthur C., 36 Osborne ter., Newark
Willan, E. H., 77 S. Munn av., E. Orange
Willey, F. Parker, 11 Park pl., Bloomfield
Williams, Irving D., 293 Central Pk., West N. Y.
Willner, Irving, 18 Waverly av., Newark
Willson, James H., 111 N. Walnut st., E. Orange
Wintsch, Carl H., 841 S. 12th st., Newark
Wolfe, J. S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wolfe, J. C., 56 Church st., Montclair
Wood, E. LeRoy, 192 Roseville av., Newark
Woodworth, L. J., 307 Montgomery, Bloomfield
Woolf, Bernard H., 15 Hedden ter., Newark
Wort, Frederick J., Jr., 1080 Broad st., Newark
Wrensch, Alex. E., 79 Valley rd., Montclair
Wyker, Arthur W., 1 Park pl., Bloomfield
Yaguda, Asher, 88 Clinton av., Newark
Ylvisaker, Lauritz, Pru. Ins. Co., Newark
Young, I. H., 654 Lyons av., Irvington
Young, John H., 37 N. Fullerton av., Montclair
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmerman, R., 91 Clinton av., Newark
Zweigel, I., 92 Sunnyside ter., East Orange

Honorary Members

McEwen, Floy, Newark
Rusby, Henry H.

Transfers

Smith, Harold W., from N. Y. Co., to Essex Co.
Olmstead, W. D., from Atlantic Co.back to Atl.Co.
White, Robert R., from Sussex Co., to Essex Co.

Resigned

Brady, Raymond J., Newark

Number of members and basis of representation, 725.

100 per cent paid up membership, Feb. 1, 1933.
*Deceased.

Associate Members

Alford, Ralph I., 9 N. Mountain av., Montclair
Applebaum, Irving L., 304 Fairmount av., N'w'k
Cohen, I. E., 67 Hunterdon st., Newark
Davis, Louis, 825 So. 10th st., Newark
Deignan, Wm. L., 257 Dodd st., E. Orange
Deutel, O. R., 283 Franklin st., Bloomfield
Dranow, Paul, 205 Franklin av., Nutley
Freidman, Harry, 721 S. 16th st., Newark
Golden, Clement H., 81 Seymour av., Newark
Israeloff, Howard H., 7 Frederick ter., Irvington
Kleinman, Maurice, 845 Clinton av., Newark
Levinson, Robt. M., 369 So. 12th st., Newark
Maggio, George A., 110 Fleming av., Newark
Pavia, John R., 158 Hunterdon st., Newark
Perham, Betram S., 199 Lorraine av., U. Montcl'r
Plain, I. H., 2 Stratford pl., Newark
Roberts, A. H., 24 S. 9th st., Newark
Russomanno, R. L., 181 Clinton av., Newark
Sax, Max T., 84 Grove st., Bloomfield
Sheehan, D. C., 773 Sanford av., Newark
Stage, Earl, 601 Clinton av., Newark
Stoddard, Gordon V., 41 S. Munn av., E. Orange
Van Duzer, R. B., 304 Park st., Up. Montclair
Wambsganss, M., 44 Devine st., Newark
Zweibel, Leonard, 2 Columbia av., Newark

GLOUCESTER COUNTY (8)

Society organized December, 1818. Meets third Wednesday from November to June. Annual meeting in November.

President

Pedrick, Wm. D., Glassboro

Vice-President

Livengood, B. A., Swedesboro

Secretary and Treasurer

Hollinshed, Ralph K., Westville

Reporter

Diverty, Henry B., Woodbury

Censors

Stout, H. W., Chairman, Wenonah
Sinexon, H. L., Paulsboro
Ulmer, Chester I., Gibbstown

Asheraft, Samuel F., Mullica Hill
Barrows, Victor, Pitman
Black, Alan B., Clarksboro
Brewer William, Woodbury
Campbell, Duncan, Woodbury
Carpenter, William H., Woodbury
Crain, W. E., Mt. Ephraim
Diverty, Henry B., Woodbury
Downs, Elwood E., Woodbury
Fooder, H. M., Williamstown
Gairdner, T. M., Gibbstown
Hillegas, E. J., Mantua
Hollinshed, Ralph K., Westville
Knight, I. Warner, Pitman
Livengood, B. A., Swedesboro
Lumis, M. F., Pitman
Moore, Ralph L., Woodbury
Nelson, Harry, Woodbury
Pedrick, Charles D., Glassboro
Pedrick, William W., Glassboro
Rhoads, S Creadick, Westville
Ristine, Edwin R., Westville

GLOUCESTER COUNTY—Continued

Rogers, Dorothy, Woodbury
Sheets, C. C., Paulsboro
Sherman, Fuller G., Woodbury
Sinexon, Harry L., Paulsboro
Sooy, L. T., Pitman
Stewart, Irving J., Swedesboro
Stout, Harry Wilson, Wenonah
Ulmer, Chester I., Gibbstown
Underwood, J. Harris, Woodbury
Weems, Don, Wenonah
Wondall, F. G,. Clayton
Wood, Oram A., Paulsboro

Honorary Members

Palen, G. J., 1419 Spruce st., Philadelphia, Pa.

Number of members and basis of representation, 34.

100 per cent paid up membership, Feb. 1, 1933.

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets the first Tuesday in every month. Annual meeting in October.

President

Pyle, Louis A., Jersey City

Vice-President

Klaus, Henry, Union City

Secretary

Schwarz, Barthold T. D., Jersey City

Treasurer

Kelley, Charles B., Jersey City

Reporter

Sirken, Charles, Jersey City

Censors

Cassidy, J. M., Jersey City
Jaffin, A. E., Jersey City
Luippold, E. J., Weehawken

Adams, Samuel, 29 Highland av., Jersey City
Africano, J. V., 4246 Hudson blvd., Union City
Africano, S., 526, 15th st., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Alexander, Hugo, 1029 Garden st., Hoboken
Allen, Issac L., 521 Palisade av., Union City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 406 Fairmount av., Jer. City
Angelo, Jos. A., 1190 Paterson Plank rd., Secaucus
Aria, Michael, 31 Glenwood av., Jersey City
Arlitz, William J., 107 Newark st., Hoboken
Ash, Arthur F., 710 Boulevard East, Weehawken
Auriemma, Michael, 419 Adams st., Hoboken
Axford, W. H., 840 Boulevard, Bayonne
Baechler, Jules, 439 16th st., W. New York
Bahnson, Conrad M., 170 Bowers st., Jersey City
Ballinger, Reeve L., 659 Kearny av., Arlington
Banach, Leon, 2747 Boulevard, Jersey City
Barbarito, William N., 2671 Boulevard, Jer. City
Barishaw, S. B., 5 Bentley av., Jersey City
Barrett, A. F., 835 Montgomery st., Jersey City
Bartlett, W. M., 180 Bergen av., Jersey City
Behrens, Herman, 312 Webster av., Jersey City
Ben-Asher, Solomon, 260 Bergen av., Jer. City
Bender, Max, 327 23rd st., Union City
Benjamin, Harold C., 59 Crescent av., Jersey City
Berlin, J. I., 9 Gifford av., Jersey City
Binder, Joseph, 422 Bergen av., Jersey City
Bitten, Robert M., 33 Romaine av., Jersey City
Blakey, A. P., 475 Jersey av., Jersey City
Blanchard, O. R., 37 Clinton av., Jersey City
Bookrajian, Edw. N., 5436 Hudson blvd., N.B'rg'n
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Bottl, John A., 236 Summit av., Jersey City
Bowen, Horace, 2787 Boulevard, Jersey City
Bowyer, Frank F., 50 Gifford av., Jersey City
Brady, Thos. S , 678 Ave. C, Bayonne
Brady, William, 403 46th st., Union City
Branch, W. Harold, 190 Duncan av., Jersey City
Brandenberg, Leo W., 4620 Boulevard, Union City
Brauer, Selig, 242 Bergen av., Jersey City
Braunstein, S. C., 424 13th st., West New York
Braunstein, Wm. P., 831 Boulevard, E. W'hawk'n
Brennock, Thos. McG., 3 Webster av., Jersey City
Brick, G. J., 43 Cottage st., Jersey City
Broesser, H. V., Hoboken Bank for Savings, Hob'n
Brooke, W. W., 915 Ave. C, Bayonne
Brophy, Francis X., 705 Bergen av., Jersey City
Brodowski, John J., 554½ Jersey av., Jer. City
Bruder, A. J., 344 Fairmount av., Jersey City
Butler, Vincent P., 921 Bergen av., Jersey City
Callery, Wm., 4 Columbia ter., Weehawken
Cannon, Edw. A., 5360 Hudson blvd., N. Bergen
Carr, Mary B., 1 Astor pl., Jersey City
Cassidy, John M., 1913 Boulevard, Jersey City
Chapman, E. J., 203 Danforth av., Jersey City
Chayes, Sidney, 980 Ave. C, Bayonne
Child, Frank M., 1222 Bloomfield st., Hoboken
Christian, Henry A., 111 Fairview av., Jersey City
Clark, Chas. C., 461 New York av., Union City
Cobham, James L., 78 Brinkerhoff st., Jer. City
Cohen, Harry F., 660 Jersey av., Jersey City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 714 Park av., Hoboken
Cohen, Samuel A., 112 Mercer st., Jersey City
Comora, Herman C., 317 16th st., West New York
Connell, Emmet J., 2227 Blvd., Jersey City
Connell, John, 977 Summit av., Jersey City
Connell, John N., 26 Carlton av., Jersey City
Connolly, Thos. W., 921 Bergen av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Cosgrove, Samuel A., 254 Union st., Jersey City
Cracco, Fred A., 51 Palisade av., Union City
Crowley, Leo F., 148 Belmont av., Jersey City
Culver, Geo. M., 25 Glenwood av., Jersey City
Culver, S. Herbert, 75 Magnolia av., Jersey City
Curtis, Grant P., 312 36th st., Union City
D'Acierno, P., 346 Palisade av., Union City
Daly, Bert, 151 Ave. C, Bayonne
Daly, E. J., 921 Bergen av., Jersey City
Davey, Thomas N., 41 West 33rd st., Bayonne
Decker, Clinton L., 40 S. Kingman rd., S. Orange
DeFuccio, C. P., 47 Glenwood av., Jersey City
DeMeritt, C. L., 415 32d st., Hoboken
Dennis, Louis A., 42 McLaren st., Red Bank
Dexter, Harriet E. T., 903 Ave. C, Bayonne
Dillingham, W. I., 431 15th st., West New York
Dodson, Louis, 592 Jersey av., Jersey City
Dolganos, Moses 268 Palisade av., Jersey City
Donohoe, L. F., 140 West 8th st., Bayonne
Doody, Wm. M., 19 Bentley av., Jersey City

HUDSON COUNTY—Continued

Doran, Ralph J., 200 11th st., Hoboken
Doran, Wm. G., 921 Bergen av., Jersey City
Dougherty, Dan. D., 206 10th st., Hoboken
Draessel, Chas., 509 22d st., Union City
Duckett, Warren J., 21 Carlton av., Jersey City
Dukes, H. R., 220 Kearny av., Kearny
Eckert, William, 672 Palisade av., Union City
Eckes, Joseph, 197 Hancock av., Jersey City
Edgar, Joseph A., 71 Congress st., Jersey City
Edwards, Lena, 358 Pacific av., Jersey City
Elsasser Theo.. 906 Park av., Woodcliff
Enright, J. G., 25 Kensington av., Jersey City
Evans, James L., 893 Park av., N. Bergen
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Farr, J. C., 75 10th st., Hoboken
Feit, Herman, 7 Kensington av., Jersey City
Fellman, M., 118 Jewett av., Jersey City
Ferenczi, Louis J., 33 Edwards st., Bayonne
Fineberg, Bernard J., 874 Bergen av., Jersey City
Fineberg, Jacob, 116 Bergen av., Jersey City
Finke, Chas. H., 317 York st., Jersey City
Finn, Frederick A., 921 Bergen av., Jersey City
Flaherty, M. E., 36 Glenwood av., Jersey City
Flichtenfeld, Morris, 283 4th st., Jersey City
Forman, H. S., 640 Bergen av., Jersey City
Frank, Morris, 920 Ave. C, Bayonne
Franklin, I. Harold, 191 Palisade av., Jersey City
Franklin, Louis, 191 Palisade av., Jersey City
Friele, Wm., 25 Tonnele av., Jersey City
Frundt, Oscar C., 92 Bartholdi av., Jersey City
Furlonge, H. Rowland, 432 Jackson av., Jer. City
Furman, Sol T., 88 Kensington av., Jersey City
Gardner, John W., 636 Ocean av., Jersey City
Gerne, Timothy, 972 Summit av., Jersey City
Ghee, Euclid P., 115 Clairmont av., Jersey City
Gille, Hugo, 149 Congress st., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleeson, Wm. John, 37 Monticello av., Jersey City
Godlin, David R., 5580 Hudson blvd., N. Bergen
*Goldberg, E. H., 238 Kearny av., Kearny
Gordon, I. L., 1815 Boulevard, Jersey City
Goudy, E. S., 187 Kearny av., Kearny
Gould, J. H., 696 Ave. C, Bayonne
Granelli, H. A., 213 Garden st., Hoboken
Greenberg, Philip, 1902 Hudson blvd., Jersey City
Greene, Albert D., 195 Palisade av., Union City
Greissinger, Karl, 422 20th st., West New York
Haggerty, Francis F., 1015 Wash. av., Hoboken
Hall, Perry O., 254 Union st., Jersey City
Halligan, Earl J., 254 Montgomery st., Jer. City
Halligan, Harold J., 254 Montgomery st., Jer. C'y
Halpern, Sophia L., 271 Palisade av., Union City
Hamill, P. J., 50 Journal Square, Jersey City
Hammer, Walter P., 306 16th st., W. New York
Hardenberg, D. S., 347 Communipaw av., J. City
Harris, Charles M., 501 Bergen av., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. A., 777 Boulevard East, Weehawken
Harvey, John W., 818 Ave C, Bayonne
Hasking, Arthur P., 318 Montgomery st., Jer. City
Heilbrunn, Julius, 135 Belmont Ave., Jersey City
Heintzelman, B. S., 19 W. 33rd st., Bayonne
Hekimian, J. H., 468 Palisade av., Weehawken
Hernandez, Manuel, 1974 Hudson blvd., Jer. City
Herradora, J. R., 50 Journal Square, Jersey City
Higgins, G. L., 94 Lembeck av., Jersey City
Higgins, Thos. A., 2616 Hudson blvd., Jersey City
Hill, William F., 108 Grand st., Jersey City
Hoffman, P., 2672 Boulevard, Jersey City
*Holloway, J. Morgan, 633 Bergen av., Jersey City
Hommell, P. E., 689 Bergen av., Jersey City
Hoops, Harold J., 167 Ege av., Jersey City
Introcaso, D. A., 45 Crescent av., Jersey City
Ishkhanian, N. J., 656 Palisade av., West New Y'k
Jacks, Oscar, 476 Mercer st., Jersey City
Jacques, J. Eugenia, 74 Waverly st., Jersey City
Jaffee, Herman, 112 Bergen av., Jersey City
Jaffin, A. E., 41 Emory st., Jersey City
Jentz, John H., 63 Sherman pl., Jersey City
Jones, J. M., 317 Prospect st., Ridgewood
Joseph, B. M. 50 Gleenwood av., Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Justin, J. Clement, 413 16th st., W. New York
Kaplan, Herman B., 324 44th st., Union City
Kearney, John V., 410 Bergenline av., Union City
Keegan, Thos. D., 117 Kensington av., Jer. City
Kelley, Chas. B., Trust Co. of N. J. Bldg., Jer. City
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kelly, James E., 1885 Boulevard, Jersey City
Kerdasha, Geo. S., 131 31st st., N. Bergen
Kiley, Eugene M., 730 Hudson st., Hoboken
King, Geo. W., Hud. Co. Hos. for Insane, Secaucus
Klaus, Henry, 435 Palisade av., Union City
Klugman, Louis W., 375 Ave. C, Bayonne
Kolb, J. M., 725 10th st., Union City
Kooperman, B., 221 16th st., West New York
Kooperstein, Samuel, 395 Ogden av., Jersey City
Koppel, Joseph, 921 Bergen av., Jersey City
Koppel, Leo A., 921 Bergen av., Jersey City
Kresch, Philip, 42 W. 22nd st., Bayonne
Kuhlmann, Alvin E., 527 37th st., Union City
Lambert, F. E., 157 Ocean av., Jersey City
Lange, Louis C., 50 Clifton ter., Weehawken
Largay, Arthur O., 937 Ave. C, Bayonne
Larkey, Charles J., 700 Ave. C, Bayonne
Larkin, Joseph J., 546 Bramhall av., Jersey City
Lawsing, G. Condi, 443 22nd st., West New York
Lefkowitz, Jacob H., 445 20th st., West New York
Leining, Albert, 1 4th st., Weehawken
Lemmerz, Theodore H., 141 Magnolia av., Jer. C'y
Levine, Israel, 106 Bowers st., Jersey City
Levine, G. I., 1861 Boulevard, Jersey City
Lewis, Livingston L., 712 Washington st., Hob'k'n
Linden, Mortimer H., 45 Clendenny av., Jer. City
Lindroth, Lawrence V., 4633 Hudson Blvd., J. City
Little, Alonzo W., 120 Arlington av., Jersey City
Londrigan, Jos. F., 1000 Hudson st., Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Loori, Wm., 549 Pavonia av., Jersey City
Luczynski, Edw., 38 W. 26th st., Bayonne
Luippold, E. J., 85 Col. ter., Weehawken
Lupin, Edward E., 727 Ave. C, Bayonne
Lynch, Roland J., 93 Fairview av., Jersey City
Macchia, Benj. J., 262 Montgomery st., Jer. City
Madaras, John F., 907 Ave. C, Bayonne
Madden, Wm. L., 30 Kensington av., Jersey City
Mallalieu, Frank W., 16 Monticello av., Jer. City
Mangone, Geo. F., 171 Palisade av., Union City
Maras, Peter E., 80 Tonnele av., Jersey City
Markowitz, B. B., 2157 Boulevard, Jersey City
Markowitz, Irwin, 2157 Boulevard, Jersey City
Marks, David M., 298 Fourth st, Jersey City
Marrone, John A., 233 Bowers st., Jersey City
Marshak, Martin I., 679 Ave. C, Bayonne
Marshall, Frank A., 200 Jane st., Weehawken
Matera, Joseph, 506 Garden st., Hoboken
Mathesheimer, J. L., 280 Old Bergen rd., Jer. City
Matthews, Wm. J., 938 Hudson st., Hoboken
Maturi, V. E., 814 Boulevard, Bayonne
Mayer, Wm. W., 532 Bergen av., Jersey City
McDede, J. Searle, 215 Ege av., Jersey City
McDonald, F. R., 79 Summit av., Jersey City
McLean, Herbert E., 92 Fairview av., Jer. City

HUDSON COUNTY—Continued

McLean, Hugh A., 414 17th st., West New York
McLean, John J., 92 Fairview av., Jersey City
McLoughlin, Frank J., 558 Jersey av., Jer. City
McNenney, C. E., 113 Fairview av., Jersey City
Mead, Walter G., 699 Kearny av. Arlington
Meehan, Geo. Edw., 117 Mercer st., Jersey City
Meltsner, L., 904 Hudson st., Hoboken
Mendelsohn, Lewis, 272 Montgomery st., Jer City
Mersheimer, Chris. H., 15 Reservoir av., Jer. City
Meyer, Wm., 436 New York av., Union City
Miller, M. H., 311 16th st., West New York
Miner, Donald, 921 Bergen av., Jersey City
Monoghan, Wm. J., Secaucus
Morley, Grace C., 440 Palisade av., Weehawken
Morris, D. G., 11 W. 26th st., Bayonne
Mount, Elmer M., 74 Sherman pl., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Murphy, Edward A., 1 Britton st., Jersey City
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Patrick H. W., 27 Jefferson av., Jer. C'y
Murray, Jos. A., 765 Ave. C, Bayonne
Mustermann, Otto H., 234 48th st., Union City
Muttart, George W., 702 Ocean av., Jersey City
Mutter, Alfred A., 75 Beech st., Kearny
Nafash, M., Shafesk, 402 21st st., Union City
Nalitt, David I., 28 W. 33rd st., Bayonne
Nattrass, R. B., 204 11th st., Hoboken
Nay, Charles K., 164 Palisade av., Jersey City
Nelson, Aaron, 462 Jersey av., Jersey City
Nevin, John, 921 Bergen av., Jersey City
Newman, Abraham J., 69 Sherman pl., Jer. City
Nicholson, Frank, 895 Summit av., Jersey City
Niemeyer, Chas. V., 4610 Boulevard, Weehawken
Norton, James F., 299 Varick st., Jersey City
Nuse, Edward F., 550½ Jersey av., Jersey City
Ockene, Abraham, 495 Palisade av., Union City
O'Connor, B. A., 314 North 4th st., Harrison
O'Connor, John J., 434 New York av., Union City
Oestman, A. W., 932 Summit av., Jer. City Hgts.
O'Gorman, Wm., 921 Bergen av., Jersey City
O'Hanlon, George, Jersey City Hosp., Jersey City
Older, Benj., 435 New York av., Union City
Olpp, A. E., 318 Bergenline av., Union City
O'Neill, John H., 270 Montgomery st., Jer. City
Opdyke, L. A., 55 Clinton av., Jersey City
O'Shea, John J., 135 Shippen st., Weehawken
Oshrin, Henry, 750 Park av., West New York
Ovens, R. C., 675 Bergen av., Jersey City
Owen, Logan S., 938 Hudson st., Hoboken
Paganelli, T. R., 1006 Garden st., Hoboken
Peretzmann, J., 920 Hudson st., Hoboken
Pearlstein, Frank, 325 16th st., West New York
Perkel, Louis L., 3263 Boulevard, Jersey C'ty
Pellarin, John D., 493 New York av., Union City
Pentel, Louis S., 307 16th st., West New York
Perlberg, Harry J., 921 Bergen av., Jersey City
Peters, Chas M., 921 Bergen av., Jersey City
Peters, E. A. P., 394 Bergen av., Jersey City
Peterson, C. A., 921 Washington st., Hoboken
Pindar, Fred S., 960 Park av., N. Bergen
Pindar, W. A., 975 Broadway, Woodcliffe
Pinkerton, Wm. A., 854 Ave. C, Bayonne
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 5407 Hudson blvd., N. Bergen
Pollak, B. S., Hud. Co. Tbc. Hos. & San., Secaucus
Potter, Benj. Paul, Hud. Co., Tub. San., Secaucus
Povalski, Alex. W., 1925 Boulevard, Jersey City
Pontery, Herbert, 89 Bowers st., Jersey City
Purdy, Chas H., 35 Highland av, Jersey City
Pyle, Immanuel, 51 Monticello av., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Pyle, Wallace, 15 Exchange pl., Jersey City
*Pyle, Wm. L., 678 Bergen av., Jersey City
Quigley, Frederic J., 4622 Boulevard, Union C'y
Quinn, John J., 152 Harrison av., Jersey City
Read, Jessie D., 166 Summit av., Jersey City
Rector, Joseph M., 681 Bergen av., Jersey City
Reingold, Alexander, 221 Garden st., Hoboken
Reitnauer, John S., 518 44th st., Union City
Rieck, Walter R., 379 Kearny av., Kearny
Rieman, Aloysius, 3566 Hudson blvd., Jer. City
Robbins, Henry B., 144 Mercer st., Jersey City
Rosenberg, Albert B., 1921 Blvd., Jersey City
Rosenberg, J., 692 Bergen av., Jersey City
Rosecrans, James H., 826 Hudson st., Hoboken
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rowe, Norman L., 828 Grand st., Jersey City
Rundlett, Emelia V., 79 Prospect st., Jer. City
Ruoff, Andrew C., 494 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Ruvane, J. J., 38 Bentley av., Jersey City
Sacco, Anthony G., 440 New York av., Union City
Sachs, Fred, 177 Bergen av., Jersey City
Sachs, Wilbert, 921 Bergen av., Jersey City
Salmon, Edward H., 669 Bergen av., Jersey City
Saradarian, Albert V., 481 N. Y. av., Union City
Santosky, Benjamin B., 162 Bergen av., Jer. City
Santangelo, Stephen, 304 Varick st., Jersey City
Schapiro, Joseph, 712 Palisade av., Union City
Schenker, B. N., 246 5th st., Jersey City
Schlein, August, 707 Park av., Hoboken
Schept, Samuel S., 523 37th st., Union City
Schneckendorf, S., 203 Harrison av., Jersey City
Schneider, Louis A., 412 17th st., West New York
Schuchner, Wm. F., 264 1st st., Jersey City
Schulman, A. S., 4638 Hudson blvd., Union City
Schuck, Traugott E., 58 9th st., Hoboken
Schurman, E. W., 710 Ocean av., Jersey City
Schwarz, B. T.D., 2801 Hudson blvd., Jersey City
Schwartz, Henry J., 5560 Hudson blvd., N.Bergen
Schwarz, W. J. A., 269 Cator av., Jersey City
Scott, Samuel G., 141 Bergen av., Jersey City
Sciorsci, Edw. P., 609 Bloomfield st., Hoboken
Selinger, S., 413 16th st., West New York
Sena, Marie A., 5674 Boulevard, N. Bergen
Sesta, Jos., 282 Fulton av., Jersey City
Sexsmith, George H., 719 Ave. C, Bayonne
Shapiro, Maurice, 750 Ave C, Bayonne
Shapiro, Nathaniel, 192 Palisade av., Union City
Sheeran, Vincent J., 269 Jewett av., Jersey City
Shipman, Frank C., 3663 Boulevard, Jersey City
Shook, B. E., 284 Bergen av., Jersey City
Short, Francis J., 670 Jersey av., Jersey City
Shulman, N. L., 538 45th st., Union City
Siegler, Julius, 646 Bergen av., Jersey City
Simeone, Peter A., 555 38th st., Union City
Sirken, Chas., 887 Summit av., Jersey City
Smith, Alex. L., 267 Boulevard, Jersey City
Snyder, J. E. C., 1023 Garden st., Hoboken
Spalding, H. J., 512 45th st., Union City
Spano, Frank, 320 47th st., Union City
Spath, George, 722 Hudson st., Hoboken
Spence, Henry, 2540 Blvd., Jersey City
Sprague, Seth B., 301 York st., Jersey City
Steadman, E. T., 107 Christopher st., Montclair
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robt., 364 Boulevard, Jersey City
Stout, J. P., 165 Jewett st., Jersey City
Street, D. B., 27 Woodlawn av., Jersey City
Stuart, William C., 518 Hudson st., Hoboken
Sullivan, D. C., 22 Fairmount ter., Jersey City
Sullivan, George F., 510 Hudson st., Hoboken
Sullivan, James A., 668 Jersey av., Jersey City
Sullivan, Margaret N., 70 Undercliffe rd., Monte'r

HUDSON COUNTY—Continued

Sulouff, S. Henry, 662 Newark av., Jersey City
Sweeney, William J., 68 Clifton ter., Weehawken
Swiney, Merrill A., 325 Ave. C, Bayonne
Tannert, C. H., 331 33rd st., Woodcliffe
Tataryan, H., 422 New York av., Union City
Temes, J. Howard, 293 Ege av., Jersey City
*Terk, A. P., 295 Connant st., New York, N. Y.
Thomas, Ralph B., 793 Montgomery st., Jer. City
Thum, Ernest, 819 Ave. C, Bayonne
Tidwell, H. F., 229 16th st., West New York
Timlin, James W., 64 Beech st., Arlington
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 495 New York av., Union City
Varriano, John L., 3258 Boulevard, Jersey City
Visconti, Jos. A., 711 Garden st., Hoboken
Vitale, Dominick, 646 Palisade av., West New Y'k
Von Deesten, Henry T., 268 Palisade av., Jer. C'y
Vostrosablin, Nicholas A., 121 Grand st., Jer. City
Vreeland, Hamilton, 232 S. Irving st., Ridgewood
Vreeland, William N., 32 Bergen av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 60 Glenwood av., Jer. City
Weber, Walter D., 305 23rd st., Union City
Wechsler, Joseph, 3342 Boulevard, Jersey City
Weiss, Abraham, 456 Palisade av., Weehawken
Weiss, M. J., 734 Ave C., Bayonne
Welcher, H. A., 5446 Hudson Boulevard, N.Bergen
Wheeler, James A., 85 Van Reypen st., Jer City
White, Hugh M., 901 Summit av., Jersey City
White, Thomas J., 221 Union st., Jersey City
Wilcox, Frank A., 415 16th st., West New York
Wilkinson, George, 144 Old Bergen rd., Jer. City
Williamson, W. L., 22 West 22nd st., Bayonne
Willis, John, 624 Pavonia av., Jersey City
Winter, Daniel T., Jr., 8 Gifford av., Jersey City
Woelfle, Henry E., 69 Sherman pl., Jersey City
Woodruff, S. R., 16 Enos pl., Jersey City
Yeaton, W. L., 204 11th st., Hoboken
Yudkoff, Wm., 403 Boulevard, Bayonne
Zenneck, J. F., 17 Fourth st., Weehawken
Zitani, Alfred M., 513 Park av., Hoboken

Associate Members

Bergen, Marshall, 273 Bergen av., Jersey City
Barone, Francis A., 175 Fulton st., Jersey City
Driscoll, Raymond S., 919 Boulevard, Bayonne
Feinberg, Harry, 11 W. 23d st., Bayonne
Fialk, Harry, 541 44th st., Union City
Frank, Nathan, 186 Bowers st., Jersey City
Frieman, Hyman, 744 Ave. C, Bayonne
Garibaldi, Louis J., 1016 Hudson st., Hoboken
Ghee, Peter F., 736 Ocean av., Jersey City
Hollywood, Jas. L., 34a Bartholdi av., Jersey City
Jenson, Grover H., 169 Lexington av., Jersey City
Leir, J. Krevin, 9 Garrison av., Jersey City
Lucas, W. Fred, 115 Van Wagenn av., Jersey C'y
Lynn, Irving I., 272 Barrow st., Jersey City
Mulvihill, Wm. J., 275 Hudson Blvd., Bayonne
O'Sullivan, J. R., 285 Chestnut st., Kearny
Pagliughi, J. J., 401 18th st., Union City
Piltz, George F., 153 25th st., Guttenberg, N. J.
Stasiva, Stanley J., 11 E. 25th st., Bayonne
Tomaiuoli, Michele, 2 Fulton st., Weehawken

Transfers

Christensen, A. H., to Hunterdon Co.
Kahrs, Benjamin, to Essex Co.

Resigned

Leavity, Benjamin
Nichols, G. Louis

Number of members and basis of representation, 419.

*Deceased

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets third Tuesday in April and October. Annual meeting in October.

President

McCorkle, W. E., Ringoes

First Vice-President

Thomas, F. Ashley, Flemington

Second Vice-President

Bootby, I. Roland, Clinton

Secretary

Fuhrmann, Barclay S., Flemington

Treasurer

Closson, Edward W., Lambertville

Reporter

Fuhrmann, Barclay S., Flemington

Censors

Tompkins, G. B.
Coleman, A. H.
English, S. B.

Boothby I. R., Clinton
Boyer, Charles G., Annandale
Chamberlain, John L., Sergeantsville
Christensen, A. H., Lebanon
Clark, Frank G., White House Station
Coleman, A. H., Clinton
Closson, Edward W., Lambertville
Decker, F. H., Frenchtown
English, Samuel B., Glen Gardner
Fuhrmann, Barclay Stokes, Flemington
Fulper, Theodore B., Hampton
Gramsch, Louis A., Glen Gardner
Harmon, Byron M., Essex Co. Sanitarium, Verona
Harmon, Harry M., Frenchtown
Heil, A. Arling, Milford
Henry, George, Flemington
Knox, Howard A., New Hampton
Leaver, Morris H., Quakertown
Lane, E. W., Bloomsbury
McCorkle, W. E., Ringoes
Rufe, John J., High Bridge

HUNTERDON COUNTY—Continued

Slavin, Paul, Glen Gardner
Thomas, Floyd A., Flemington
Tompkins, Grenelle B., Flemington
Topkins, Isidor I., Califon

Honorary Members

Sommer, George N. J., Trenton

Resigned

Salmon, L. T., Lambertville
Williams, L. C., Lambertville

Number of members and basis of representation, 25.

100 per cent paid up membership, Feb. 1, 1933.

*Deceased.

MERCER COUNTY (11)

Society organized May 23, 1848. Meets second Wednesday in each month except July, August and September. Annual meeting in December.

President

Proctor, Francis E., Trenton

Vice-President

Connelly, John A., Trenton

Secretary and Reporter

Hutchinson, A. Dunbar, Trenton

Treasurer

North, Harry R., Trenton

Censors

Seely, R. B., Trenton
Mitchell, Chas. H., 1100 West State st., Trenton
Schauffler, William G., Princeton

Abey, W. J. H., 23 N. Delaware av., Pennington
Ackley, David B., 21 N. Clinton av., Trenton
Adams, Chas. F., 34 W. State st., Trenton
Applegate, Edw. T. R., 1125 Greenw'd av., Trent'n
Applestein, Robert, 569 E. State st., Trenton
*Armstrong, Alexander, White Haven, Pa.
Aronis, H. R., 239 E. Hanover st., Trenton.
*Arthur, Francis M., Hamilton Square, Trenton
Ashley, H. H., 192 W. State st., Trenton
Atkinson, Alvan W., 423 E. State st., Trenton
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, R. G., 807 W. State st., Trenton
Beairsto, E. B., 178 W. State st., Trenton
Belford, R. J., 1st Nat. Bank Bldg., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Belting, Arthur W., P. O. Box 68, Trenton
Berger, Harry, 921 Clinton av., Trenton
Berman, Jacob J., 409 Market st., Trenton
Blackwell, Enouch, Trenton Trust Bldg., Trenton
Blaugrund, Samuel, 190 W. State st., Trenton
Blum, Joseph M., 128 Mill st., Trenton
Bowman, A. K., 272 Nassau st., Princeton
Carroll, C. Walter, 117 Centre st., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Child, Florence C., 317 City Hall, Trenton
Cohen, C. C., 217 W. Hanover st. Trenton
Cohen, Herman, 1419 Hamilton av., Trenton
Collier, Wm. S., 1000 S. Broad st., Trenton
Collins, Henry J., 1160 Hamilton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Connelly, John A., 212 W. State st., Trenton
Corio, Geo. A., 309 Clinton av., Trenton
Corrigan, Patrick H., 1720 Broad st., Trenton
Costill, Henry B., 371 Hamilton av., Trenton
Cotton, Henry A., State Hospital, Trenton
Cottone, R. J., 683 Princeton av., Trenton
Cowlbeck, H. D., 224 W. State st., Trenton
Cox, Harold G., Hightstown
Crane, J. Welling, State Prison, Trenton.
D'Arcy, Walter E., 545 E. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davison, Royden W., 201 W. State st., Trenton
Denelsbeck, J. Otis, 878 E. State st., Trenton
Douress, Philip C., 802 E. State st., Trenton
Elias, Elmer J., 553 S. Broad st., Trenton
Epstein, Harry H., 225 Perry st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Farmer, W. D., Allentown
Fee, Elam K., Lawrenceville
Fell, Alton S., 529 E. State st., Trenton
Finegan, P. J., 752 Greenwood av., Trenton
Franklin, C. C., 1012 Hamilton av., Trenton
Friedman, M. H., 526 N. Clinton av., Trenton
Friedmann, Leonard L., 484 Princeton av.,Tr'nt'n
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Funkhouser, Edgar B., State Hospital, Trenton
Gibbs, Jonathan C., 34 Spring st., Trenton
Goldberg, Benjamin M., 1156 E. State st., Trent'n
Gordon, Clark H., 808 State st., Trenton
Graham, E. E., P. O. Box 195, Yardsville
Guglielmelli, A. D., 449 Hamilton av., Trenton
Haggerty, Daniel L. 227 N. Warren st., Trenton
Haney, John J., 167 Cooper st., Trenton
Harman, Wm. J., 740 W. State st., Trenton
Hiden, J. C., 199 Nassau st., Princeton
*Higgins, Joseph F., 607 Center st., Trenton
Hirschfield, B. A., 1404 Greenwood av., Trenton
Holland, John A., 194 W. State st., Trenton
Hutchinson, A. D., 913 W. State st., Trenton
Iams, Samuel H., 34 Mercer st., Princeton
Ivins, Wm. C., 214 E. Hanover st., Trenton
Jaspan, Samuel C., 280 Division st., Trenton
Kachdorian, Vartan, 930 Brunswick av., Trenton
Kent, Morton M., 233 N. Warren st., Trenton
Koplin, Nathan H., 142 W. State st., Trenton
Kuhl, Paul E., 48 N. Clinton av., Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lettiere, A. J., 320 Centre st., Trenton
Levin, Louis, 140 W. State st., Trenton
Little, William R., Pennington
MacDermid, Lynden E., Bordentown
MacFarland, Burr W., Broad St. Bk. Bldg., Tr'nt'n
Marotte, Chas. L., 1417 Clinton av., Trenton
McCullough, John H., 523 E. State st., Trenton
McDonald, John O., 194 W. State st., Trenton
McGuigan, F. A., 212 N. Warren st., Trenton
McGuire, Jas J., 122 W. State st., Trenton
Means, P. B., State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, G. H., Cranbury
Mitchell, Chas. H., 1100 W. State st., Trenton
Mitskas, T. V. J., Crosswicks
Moriconi, A. F., 438 Hamilton av., Trenton
Mras, J. N., State Hospital, Trenton
Murphy, J. A., 467 Hamilton av., Trenton
North, Harry R., 160 W. State st., Trenton

MERCER COUNTY—Continued

Oliphant, Nelson B., 152 W. State st., Trenton
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, H. Norton, 72 N. Clinton av., Trenton
Pessel, J. F., 224 W. State st., Trenton
Philips, Robert H. C., 144 W. State st., Trenton
Pierson, Carl L., 178 W. State st., Trenton
Pierson, J. R., 224 W. State st., Trenton
Pierson, Theodore A., Hopewell
Potter, Ellen C., Glen Cairn Arms, Trenton
Powis, Ethel M., 198 W. State st., Trenton
Proctor, Francis E., 1245 Greenwood av., Trent'n
Purcell, Ernest F., 800 Stuyvesant, Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
Rainey, W. G., 20 Nassau st., Princeton
*Reddan, Martin W., 126 W. state st., Trenton
Rogers, Alvin S., 126 N. Warren st., Trenton
Rogers, Lawrence H., Municipal Colony, Trenton
Rogers, W. N., 1255 Brunswick av., Trenton
Rowan, Henry M., 224 W. State st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Schauffler, Wm. G., 21 Morven pl., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Schroeder, H. J. L., 202 W. State st., Trenton
Seely, Roy B., 78 N. Clinton, Trenton
Seitzick, Hannah E., 733 Hamilton av., Trenton
Sekerak, Albert J., 977 S. Broad st., Trenton
Shaw, Jos. B., 119 S. Warren st., Trenton
Sica, Samuel, 431 E. State st., Trenton
Sill, John B., 1129 Hamilton av., Trenton
Silver, E. Drew, Hightstown
Silver, George A., Hightstown
Sinclair, Donald B., Princeton
Sinton, John Y., Imlaystown
Sista, Chas. R., 476 Hamilton av., Trenton
Slack, Clarence J., 230 W. State st., Trenton
Smith, Houghton, 1063 S. Clinton av., Trenton
Smith, W. Henley, 34 W. State st., Trenton
Sommer, Geo. N. J., 120 W. State st., Trenton
Stein, L. A., 205 Market st., Trenton
Stone, R. G., State Hospital, Trenton
Summers, A. D., 180 Nassau st., Princeton
Swern, Nathan, 130 W. State st., Trenton
Taylor, Walter A., 450 Rutherford av., Trenton
Townsend, I., 39 W. State st., Trenton
*Traub, Paul, 200 Spring st., Trenton
Treiber, Benj. A., 626 Perry st., Trenton
Turner, Irvine F. P., 224 W. State st., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Van Neste, George V., Hopewell
Vanneman, Joseph S., 180 Nassau st., Princeton
Walsh, Thomas J., 1158 E. State st., Trenton
Warter, P. J., 626 W. State st., Trenton
Waters, Chas. H., 928 W. State st., Trenton
Watson, Fred S., 811 Stuyvesant av., Trenton
Watts, Wilbur, 436 E. State st., Trenton
West, Edgar L., 443 E. State st., Trenton
Weisler, Howard, 491 Centre st., Trenton
Wikoff, J. L., 799 Pennington av., Trenton
Wilbur, William Lane, Hightstown
Williams, Geo. W., 217 N. Warren st., Trenton
Williams, Harry D., 527 E. State st., Trenton
Wright, Howard E., P. O. Box 276, Princeton
Yaeger, Leslie A., 470 Hamilton av., Trenton
Yazujian, Dikran M., 562 E. State st., Trenton
Zandt, Frederick B., Hamilton sq., Trenton
Zimskind, Joshua N., 210 W. State st., Trenton

Transferred

Cochran, Samuel, moved to Pres. Hosp., N. Y.

Honorary Members

Bergen, Elston H., Princeton
Bruyere, Abel T., Trenton
Clark, Wm. A., Trenton
MacLaren, Wm. S., Princeton
Moore, R. H., Trenton

100 per cent paid up membership, Feb. 1, 1933.

Number of members and basis of representation, 160.

*Deceased.

Associate Members

Buckley, Richard T., Peddie School, Hightstown
Blumberg, A. W., 996 S. Broad st., Trenton
Burroughs, Edmund W., 701 W. State st., Trent'n
Carroll, Wm. V., 211 Academy st., Trenton
Cohen, William, 1007 Greenwood av., Trenton
Doranz, Harold K., 38 S. Hermitage av., Trenton
D'Gianni, Nicholas H., Columbus
Dimun, John T., 960 S. Broad st., Trenton
Forer, Robert, 247 Centre st., Trenton
Hutchinson, Geo. E., Hamilton Square
Hunter, Floyd D., Hamilton Square
Ireland, Allen G., N. J. State Dept. Edu., Trenton
Kustrup, J. F., 2381 S. Broad st., Trenton
Light, Arthur S., Lawrenceville
McCandliss, W. K., State Hospital, Trenton
Mewborne, Edw. B., Lawrenceville
Meriwether, E. G., State Hospital, Trenton
Peterson, Walter R., 224 W. State st., Trenton
Poyas, Morton L., 1871 Pennington rd., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scasserra, B. B., 110 Nassau st., Trenton

MIDDLESEX COUNTY (12)

Society organized June 16, 1816. Meets third Wednesday in every month except July, August and September. Annual meeting in December.

President

Wilentz, Wm. C., Perth Amboy

Vice-President

Sullivan, Chas. J., New Brunswick

Secretary and Reporter

Klein, Edward F., Perth Amboy

Treasurer

Johnson, Frank C., New Brunswick

Anderson, John F., 195 College av., N. Brunswick
Applegate, Grov. T., 116 Liv'gst'n av., N. Br'nsw'k
Avery, Phillip S., Middl's'x Gen. Hosp., N. Bruns.
Basset, Lavern C., 320 New Market rd., Dunellen
Beekman, Jesse H, Sayerville
Berkow, Samuel G., 138 Market st., Perth Amboy
Boulden, George P., Cranbury
Breslow, S., 111 Market st., Perth Amboy
Brody, Morton J., 84 Bayard st., New Brunswick
Brown, Fred L., 67 Livingston av., N. Brunswick
Burnett, Chas. B., Main st., South River
Calvin, Charles, 80 Commerce st., Perth Amboy

MIDDLESEX COUNTY—Continued

Carroll, Edgar, Main st., Dayton
Clarke, F. W., 47 Bayard st., New Brunswick
Coble, Morris S., 102 Washington st., P. Amboy
Cohen, N. B., 232 State st., Perth Amboy
Collins, James J., Main st., Woodbridge
Condon, Wm. Jos., 50 Livingston av., N. Br'nsw'k
Cooper, I. J., 71 Livingston av., New Brunswick
Cottrell, Judson G., 159 Market st., Perth Amboy
Cronk, E. Irving, 57 Livingston av., N. Brunsw'k
Csema, E. J., 151 Somerset st., New Brunswick
Dieker, Howard, 78 Main st., South River
Erwin, Millard, 572 Prospect st, Maplewood
Fagan, Jas. L., 419 George st., New Brunswick
Falcone, C., 197 Sanford av., New Brunswick
Fanelli, Antonio, 469 Lowrie st., Perth Amboy
Faulkingham, R. J., 61 Liv'gston av., N. Bruns.
Feher, L. A. M., 196 Somerset st., N. Brunswick
Fine, H. P., 185 Market st., Perth Amboy
Fishkoff, A, 360 State st., Perth Amboy
Fithian, Geo. W., 266 High st., Perth Amboy
Forney, Norman N., Main st, Milltown
Fox, S. W., 513 Raritan av., New Brunswick
Gauzza, Valentine P., Fords
Goldberg, L., 303 No. Washington av., Dunellen
Grieve, James, 88 Market st., Perth Amboy
Gutmann, Benjamin, 51 Livingston av., N. B'w'k
Gutowski, Jos. M., 433 Brace av., Perth Amboy
Haight, Harry P., Raritan av., New Brunswick
*Hay, Joseph S., 255 High st., Perth Amboy
Haywood, Harry, 3 Elm Row, New Brunswick
Henry, Frank C., 254 State st., Perth Amboy
Henry, Frank C., Jr., 254 State st., Perth Amboy
Hilker, G. F., 463 State st., Perth Amboy
Hinton, H. S., Parlin ,
Hofer, Clarence J. M., Metuchen
Hoffman, Florentine M., 91 Bay'd st., N. Bruns.
Howell, E. G., New st., New Brunswick
Howley, Barth M., 419 George st., N. Brunswick
Hunt, A. C., 625 Middlesex av., Metuchen
Hunt, Melvin M., 16 Jackson st., South River
Japhe, N., 147 Market st., Perth Amboy
Johnson, Frank C., 51 Livingston av., N. Bruns.
Karshmer, Nathan, 422 George st., N. Brunswick
Kemeny, Mere, Carteret
Kinney, Seldon T., 250 Main st., South Amboy
Kleiber, Estella, 139 New st., New Brunswick
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, J. H., Reed st., Stelton
Koelsch, F. J., Bayard st., New Brunswick
Kovarsky, A. E., 255 State st., Perth Amboy
Kraczyk, M. J., 207 Whitehead av., New Bruns.
Kramer, S. E., 121 Market st., Perth Amboy
Leonard, Geo. F., 63 N. 5th av., New Brunswick
London, William M., 256 State st., Perth Amboy
Long, Pauline A., 20 Liv'gston av., New Brunsw'k
Longbothum, George T., Wash'gton av., Dunellen
Lund, John L., 267 High st., Perth Amboy
MacDowell, J. L, 112 State st., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Mark, Joseph, 102 Green st., Woodbridge
Marvin, Dorothy, 51 Livingston st., N. Brunsw'k
McCormick, Wm. H., 266 M'k't st., Perth Amboy
McGovern, John F., 24 Livingston av., N. Bruns.
McKiernan, Robt. L., 97 Bayard st., N. Brunsw'k
McKinstry, J. W., Jamesburg
McLeod, N. S., Highland Park
Macham, Eugene A., 112 Stevens av., So. Amboy
Meinzer, Martin S., 284 Madison av., Perth Amboy
Merrill, C. F., 16 So. 3d av., H'ghl'd P'k, N. Bruns.
Messinger, Samuel J., Chrome
Morris, Carlyle, Metuchen
Nafey, Herbert W., 51 Livingston av, N. Bruns.
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Pansy, Abraham A., 12 Jackson st, South River
Platt, Thomas H., 208 Dunellen av., Dunellen
Reason, John J., Roosevelt
Rona, Maurice, 159 Bayard st., New Brunswick
Rothschild, K., 49 Bayard st., New Brunswick
Rowland, John H., 159 New st., New Brunswick
Runyon, Lawrence P., 82 Somerset st., N. Br'w'k
Sandella, J. F., 169 New st., New Brunswick
Scott, Fred W., 103 Bayard st., New Brunswick
Sender, Fannie, 191 Whitehead st., South River
Sherman, W. E., George & Schureman, N. Br'w'k
Shull, J. Virgil, 320 High st., Perth Amboy
Silk, Chas. I., 189 Rector st., Perth Amboy
Sirott, Barnett H., 409 State st., Perth Amboy
Slobodien, Benjamin F., 107 Market st., P. Amboy
Smith, A. L. M., 62 Bayard st., New Brunswick
Smith, J. Vincent, 463 State st., Perth Amboy
Spencer, Ira T., Main st., Woodbridge
Steffen, Charles T., Dunellen av., Dunellen
Stillwell, H. C., 70 Irving pl., Rahway
Sullivan, Chas. J., 57 Paterson st., N. Brunswick
Swift, Edw. M., 285 Smith st., Perth Amboy
Taber, F. H., 3 Elm row, New Brunswick
Toy, Calvert R., 92 Bayard st., New Brunswick
Tyrrell, George W., 380 State st., Perth Amboy
Urbanski, Adrian X., 148 Market st., P. Amboy
Urbanski, Matt. F., 314 Washington st., P. Amboy
Van Dyke, Benjamin S., Cranbury
Voorhees, Howard C., 43 Bayard st., N. Brunsw'k
Walker, R. B., 108 Church st., New Brunswick
Wantoch, Joseph, Carteret
Weber, J. Francis, 264 Main st., South Amboy
Wetterberg, Louis F., 389 School st., Woodbridge
Wilentz, Wm. C., 188 Market st., Perth Amboy
Wilson, John G., 280 High st., Perth Amboy
Witmer, J. D., Metuchen
Wright, E. T., 52 Oak st., Metuchen

Associate Member

Rineberg, Irving E., New Brunswick

Transferred

Avery, Phillip S., from Monmouth Co. to Middl's'x
Devan, T. A., to Maine
Fox, S. W., from Philadelphia to Middlesex
Nieman, S. Z., granted a year's leave of absence

Number of members and basis of representation, 122.

100 per cent paid up, Feb.1, 1933.

*Deceased.

MONMOUTH COUNTY (13)

Society organized June 1, 1816. Meets second Wednesday in each month. Annual meeting in December.

President

Watkins, Robert E., Belmar

Secretary

Featherston, D. F., Asbury Park

Vice-President

Maher, John E., Long Branch

Treasurer

Gosling, Walter, Red Bank

MONMOUTH COUNTY—Continued

Reporter

MacKenzie, Robert A., Asbury Park

Censors

Clayton, John C.
Bullwinkle, F.
Herrman, Wm. G.

Ackerman, Jas. F., 1010 Grand av., Asbury Park
Albright, Louis F., Jersey av., Spring Lake
Altschul, Frank Jos., 128 Garfield av., L. Branch
*Applegate, A. T., Englishtown
Appleton, Ralph, Farmingdale
Baeseman, R. W., 501 Grand av., Asbury Park
Baker Elsworth F., State Hospital, Marlboro
Binder, Joseph, 149 Garfield av., Long Branch
Blaisdel, C. Byron, 48 Norwood av., Long Branch
Boyd, John, East Front st., Red Bank
Brown, Harvey S., Freehold
Brown, Kenneth, Asbury av., Asbury Park
Bulwinkle, Frederick, Atlantic Highlands
Campbell, Wm. K., Long Branch
Clayton, John C., Freehold
Doer, Harry, Electric Bldg., Asbury Park
Donovan, William, Brielle
DePons, S. C., 501 Grand av., Red Bank
Edelson, Samuel, 1141 Corlies av., Neptune
Fairbanks, Warren H., Freehold
Featherston, Daniel F., 506 4th av., Asbury Park
Feinberg, Harry D., 384 2d av., Long Branch
Fenton, Tennet E., Manasquan
Fisher, James A., 501 Grand av., Asbury Park
Friedman, H. H., Freehold
Gesswein, Carl A., Keyport
Gordon, J. B., Holmdel
Gosling, W. W., 23 Monmouth av., Red Bank
Groves, Charles, State Hospital, Marlboro
Gullium, W. H., 505 Fourth av., Asbury Park
Haines, Emerson S., 501 Grand av., Asbury Park
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, William, 23 Monmouth st., Red Bank
Herrman, Wm. G., 501 Grand av., Asbury Park
Hill, J. A., 511 Cedar av., Allenhurst
Holters, Otto R., 515 2d av., Asbury Park
Hunt, Geo. Halsey, Broad st., Red Bank
Ingling, Harry W., Freehold
Jamison, W. F., 501 Grand av., Asbury Park
Jordan, J. C., Manasquan
Kazman, Harold A., 406 Broadway, Long Branch
Leighton, Robt. L., 401 Ludlow av., Spring Lake
Leonard, Lothair L., 615 Asbury av., Asbury Park
Lovett, Irving K., 110 E. Front st., Red Bank
MacKenzie, R. A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, D. V., 55 E. Front st., Red Bank
Mason, Howard B., 90 W. Main st., Freehold
Mathews, William, Broad st., Red Bank
McConnell, C. W., Keansburg
Moffatt, Barclay W., Nut Swamp rd., Red Bank
Nichols, Stanley H., 501 Grand av., Asbury Park
Niemtzow, Frank, 45 E. Main st., Freehold
Opferman, J. L., Highlands
Parry, O. K., Electric Bldg., Asbury Park
Podell, Alfred, 69 W. Front st., Red Bank
Pons, C. A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Prout, Charles, 414 6th av., Asbury Park
Reynolds, G. G., 64 W. Main st., Freehold
Rosenthal, A., Atlantic Highlands
Rowland, James J., Highlands
Rubin, A. David, 401 1st av., Asbury Park
Sayre, William D., 69 Maple av., Red Bank
Scott, E. A., Belle Mead San., Belle Mead
Slocum, Harry B., Bath av., Long Branch
Strahan, F. G., 473 Broadway, Long Branch
Straughan, C. C., 23 Monmouth st., Red Bank
Strauss, Arthur, 137 Pavil av., Long Branch
Traverso, Daniel, Belmar
Trippe, C. M., 793 Asbury av., Asbury Park
Upham, Helen T., 305 Third av., Asbury Park
Villapiano, Jos. G., 710 Mattison av., Asbury Park
Warner, C. Van Norris, 78 Front st., Red Bank
Watkins, Robert E., 517 5th av., Belmar
Weiner, Joseph, Asbury Park
Wilbur, Franklin L., 504 Asbury av., Asbury P'k
Wilbur, G. F., 502 Asbury av., Asbury Park
Wilson, R. B., 86 Broad st., Red Bank
Wise, Lester D., 119 Morris av., Long Branch

Honorary Members

Beach, E. M., Long Branch
Havens, W. P., Farmingdale, N. J.

Transfered

Avery, Philip, to Middlesex Co.
Quirk, Martin, received from Sussex Co.

Number of members and basis of representation, 80.

*Deceased.

100 per cent paid up Feb. 1, 1933.

MORRIS COUNTY (14)

Society organized in 1816. Meets the second Tuesday of March, June, September and December. Two or more special meetings during the year. Annual meeting in September.

President

Pinckney, Frank H., Morristown

Vice-President

Frost, Inglis F., Morristown

Secretary

Ward, Albert J., Morristown

Treasurer

Emory, George B., Morristown

Reporter

Curry, Marcus A., Greystone Park

Historian

Kice, H. W., Wharton

Executive Committee

The Officers and
Curry, Marcus A.
Kraus, Fletcher I.
Larson, Henry M.
McElroy, Ervin

Ackerman, Edward, Dover
Allaben, Anna L., 165 South st., Morristown
Allen, Fred'k M., Morristown
Baker, August L. L., Dover
Beaver, Jennie Dean, 8 Oliphant Park, Morrist'n

MORRIS COUNTY—Continued

Bird, Frank L., Netcong
Blanchard, Charles L., 26 E. Blackwell st., Dover
Carberry, Edw. T., Wharton
Christian, Thomas B., Greystone Park
Collins, Lawrence M., Greystone Park
Comeau, George, Greystone Park
Cooper, Edward P., Hamden, N. Y.
Costello, William Francis, Dover
Coultas, A. B., Madison
Curry, Marcus A., Greystone Park
Deichman, Charles H., Morristown
*DeGroot, George S., Mendham
Donovan, Joseph, Morris Plains
Eckhardt, Ralph A., Madison
Emory, George B., 1 Franklin pl., Morristown
Falvello, W. A., 28 Westmore av., Morristown
Farrow, J. Willard, Dover
Ferris, Ruth, 12 De Hart st., Morristown
Frost, Inglis F., 26 Maple av., Morristown
Galasso, Attilio, 275 Speedwell av., Morristown
Geary, Daniel J., Morristown
Gibb, W. Blake, Madison
Gilbertson, R. L., Madison
Glazebrook, Francis H., 6 Altmont ct., Morrist'n
Gordon, Charles D., Mt. Arlington
Gregory, Marie F., Green Village rd., Madison
Hampton, Geo. B., Greystone Park
Harquail, R. J., Greystone Park
Harrington, J. Henry, Rockaway
Harris, Morris, 82 Maple av., Morristown
Hatch, Elvira D., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Heinig, Frank G., Boonton
Hubert, Antonio, 133 Main st., Rockaway
Johnson, Geo. L, Morristown
Johnston, J. F., 209 Main st., Chatham
Kice, Henry W., Wharton
King, Alden P., Succasunna
Kossmann, Walter J., Pompton Plains
Krauss, Fletcher I., Chatham
Kuite, George B., Morris Plains
Laatsch, C. E. F., Greystone Park
Lane, Arthur K., Greystone Park
Larson, Henry M., 36 Franklin st., Morristown
Lathrope, Geo. H., 965 Broad st., Newark
McElroy, Ervin, Rockaway
McMurtie, William A., 26 Maple av., Morristown
Mathews, Raymond H., 186 South st., Morristown
McMahon, Bernard S., Morristown
McMurray, George B., Greystone Park
Mial, Leonidas L., 38 Elm st., Morristown
Michell, George, 221 High st., Hackettstown
Miller, Thos. B., Butler
Musetto, Carmelo A., Boonton
Mutchler, Julia, Butler
Mutchler, Raymond, Butler
Owen, Fred W., 18 Franklin pl., Morristown
Peck, Ellery N., Boonton
Pinckney, Frank H., Morristown
Plume, Clarence A., Succasunna
Prager, Bert A., Chatham
Reed, F. Grendon, 52 Hill st., Morristown
Rice, Franklin W., 184 South st,. Morristown
Rubin, Henry S., Morristown
Schmidt, Hilmar R., Lincoln Park
Schmitz, Mathias, Denville
Schulman, Robert, Mendham rd., Morristown
Scott, Harrold R., Morristown
Seward, Fred H., 40 Green Village rd., Madison
Seward, Wm. H., Madison
Sherman, Byron G., Maple av., Morristown
Spencer, Alvin, 19 E. Blackwell st., Dover
Sutphen, E. Blair, 26 Maple av., Morristown
Teller, D. W., Morristown
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., 135 South st., Morristown
Truax, Alfred J., Boonton
Voorhies, Wm. S., Mendham
Ward, Albert J., 71 Washington av., Morristown
Washburn, Philip C., Greystone Park
*Wigg, Cuthbert, 434 Lathrop av., Boonton
Williams, L. E., Madison
Wolfe, W. J., 55 Fairmount av., Chatham
Young, George J., 208 Morris av., Morristown

Associate Non-members

Bishop, Louis F., New York
Emerson, Linn, East Orange
Prout, Thomas P., New York

Honorary Members

Wigg, Cuthbert, Boonton

Resigned

Reed, Ralston R.

Number of members and basis of representation, 86.

100 per cent paid up membership, Feb. 1, 1933.
*Deceased.

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets in May and November at the Convenience of the members. Annual meeting in November.

President

Sawyer, Blackwell, Lakewood

Vice-President

Goldstein, A., Lakewood

Treasurer

Brouwer, Frank, Toms River

Secretary

Woodhouse, Alfred, Toms River

Reporter

Herberner, E. G., Lakewood

Bierach, Jules, Toms River
Brouwer, Frank, Toms River
Buermann, Robert, Lakewood
Bunnell, Frederick N., Barnegat
Carmona, Louis R., Tuckerton
Denniston, Frank, Point Pleasant
Disbrow, Harold B., Lakewood
Disbrow, Vanderhoof M., Lakewood
Dodd, Wm. E., Beach Haven
Goldstein, A., Lakewood
Herbener, E. G., Lakewood
Hilliard, J., Manahawken
Lemacher, Frank, Lakewood
*Lindley, C. H., 4047 Marathon av., Los Angeles

OCEAN COUNTY—Continued

Obert, J. E., New Egypt
Ripley, Charles D., 11 Lincoln Park, Newark
Sawyer, Blackwell, Lakewood
Sickel, E. M., Lakewood
Swan, Guy H., Beachwood
Thomson, T. F., Lakewood
Tobin, Adolph, Lakewood
Woodhouse, Alfred, Toms River

Honorary Members

Jones, R. R., Toms River
Davies, Wm., Lt. Com. U. S. N. Station, Lakehurst
Riggs, Cecil, Lt. Com. U. S. N. Station, Lakehurst

Number of members and basis of representation, 21.

*Deceased

PASSAIC COUNTY (16)

Society organized January 14, 1844. Meets the second Thursday of each month except June, July and August, at the Paterson Health Centre. Annual meeting in October.

President

Bergin, Joseph, Paterson

First Vice-President

Willard, Harry S., Paterson

Second Vice-President

MacMillan, Wright, Passaic

Secretary and Reporter

Hall, Wayne W., 266 Van Houten st., Paterson

Treasurer

Taber, Leslie, Paterson

Censors

Carlisle, John H.
Morrill, J. P., Paterson
Roemer, Jacob

Allen, J. M., 377 Main av., Passaic
Apter, A. H., 669 Broadway, Paterson
Armstrong, Robt. R., 114 Pennington av., Passaic
Ash, Frank W., 108 Carroll st., Paterson
Atkinson, Jas. W., 485 S. Maple av., Glen Rock
Atwood, Edw. A., 360 Park av., Paterson
Barr, Joseph, 975 Madison av., Paterson
Becker, G. L., 646 E. 28th st., Paterson
Bender, Theo. T., 666 Broadway, Paterson
Bergin, J. V., 315 Broadway, Paterson
Beshlian, Hagop K., 7 Lee pl., Paterson
Bireley, M. F., 361 15th av., Paterson
Bohl, Louis J , 320 Broadway, Paterson
Bongiorno, Henry D., 516 Paterson st., Paterson
Bonynge, Henry A., 123 Prospect st., Ridgewood
Botbyl, B. W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brevoort, Henry M., Main st., Lodi
Bromberg, Chas. B., Passaic
Brooks, S. S., 62 12th av., Paterson
Butterfield, Arey A., Passaic Nat. Bk. Bldg., Pas'c
Cantrell, W. C., 88 Union st., Clifton
Carlisle, John H., 129 Prospect st., Passaic
Carlough, D. J., 426 Ellison st., Paterson
Caverly, Fred S., 21 Grove st., Passaic
Chapnick, M. M., 117 Paterson st., Paterson
Chase, W. E., 587 Main st., Passaic
Chester, Saul W., 264 Graham av., Paterson
Clay, Thomas A., 351 Totowa av., Paterson
Coen, Lawrence E., 88 Washington av., Clifton
Cogan, Henry, 128 Carroll st., Paterson
Cole, L. Frank, 242 Broadway, Paterson
Cortese, A. E., 119 Jasper st., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crounse, D., 84 Broadway, Passaic
Curtis, A. M., 445 Van Houten st., Paterson
*Davenport, George S., 61 Passaic av., Passaic
Dawson, Harry E., 618 24th st., Paterson
De Lario, A. J., 56 Cross st., Paterson
De Mattia, Michael, 71 Cedar st., Paterson
Denton, Peter P., 951 Madison av., Paterson
De Rosa, Armond, 150 Fair st., Paterson
De Rosa, John, 150 Fair st., Paterson
De Yoe, Leon E., 602 Broadway, Paterson
Dingman, N. M., 351 Van Houten st., Paterson
*Dingman, Thos. A., 330 Broadway, Paterson
Drake, Daniel E., Greenw'd Lake rd., Newf'ndl'd
Dunning, Walter L., 606 E. 26th st., Paterson
Durant, H. J., 526 Broadway, Paterson
Dwyer, William A., 99 Park av., Paterson
Feigenoff, Israel, 420 Broadway, Paterson
Fiering, A. M., Pompton tnpk., Mountain View
Fisher, Samuel, Madison av., Paterson
Flitcroft, William, 510 River st., Paterson
Giambra, S. M., 666 Broadway, Paterson
Gillson, Hugh V., 21 Lee pl., Paterson
Gillson, John T., 170 Broadway, Paterson
Ginsberg, Samuel, 136 Broadway, Passaic
Glasgow, Thomas, 120 Passaic av., Passaic
Golding, Harry N., 180 Carroll st., Paterson
Gordon, A., 616 Main av., Passaic
Gordon, Clifford M., 52 Main st., Paterson
Gordon, Osher, 99 Prospect st., Passaic
Graham, R. H., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Hagen, Orville R., 266 Van Houten st., Paterson
Hall, W. W., 266 Van Houten st., Paterson
Harreys, Chas. W., 306 Broadway, Paterson
Henion, Emanuel L., 16 Church st., Paterson
Hollingsworth, H. H., 86 1st st., Clifton
Holmes, F. J. E., 151 Fair st., Paterson
Holt, Herman Harold, 258 Graham av., Paterson
Irving, Albert, 758 Main av., Clifton
Izenberg, David, 158 Hamilton av., Paterson
Jahn, Albert, Pas. Nat'l Bank, Passaic
Joelson, Morris S., 670 14th av., Paterson
Johnsen, S. W., 49 Passaic av., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Kane, Charles J., 349 Grand st., Paterson
Keating, C. A., 177 Ellison st., Paterson
Keller, F. J., 795 Broadway, Paterson
Kim, Gay Bong, St. Joseph's Hospital, Paterson
Koerber, George, 136 Prospect, Passaic
Kovin, A., 123 Lexington av., Passaic
Kowalski, Louis J., 64 4th st., Passaic
Laauwe, H., 198 Haledon av., Paterson
Leonard, E. A., 80 Park av., Paterson
Levine, D. B., 282 Broadway, Paterson
Levine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av. & 30th st., P't'rs'n
Levinsohn, S., 584 Broadway, Paterson
Levy, Herman, 219 Lexington av., Passaic
Linares, A. C., 402 Market st., Paterson
Lipton, L , 67 Passaic av., Passaic
Lobsenz, N., 294 Broadway, Paterson

PASSAIC COUNTY—Continued

LoMauro, Jas. R., 70 Grove st., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucas, Henry H., 266 Van Houten st., Paterson
Lucent, S. Bell, Little Falls
MacAlister, Wm. W., 333 Van Houten st., Paters'n
MacGregor, A., 379 Ellison st., Paterson
Maclay, Joseph A., 463 E. 29th st., Paterson
MacMillan, Wright, 23 Passaic av., Passaic
McBride, Andrew F., 30 Church st., Paterson
McCamey, Kenneth E., 174 Carroll st., Paterson
McCarthy, G. L., 496 Union av., Paterson
McCoy, John C., 292 Broadway, Paterson
McDede, Frank F., 922 Main st., Paterson
McDonald, R. J., 294 Broadway, Paterson
McPherson, M. G., 171 Diamond Br.av.,Hawth'rne
Magennis, Bryan C., 170 Hamilton av., Paterson
Manley, Thos. E., 390 Park av., Paterson
Maps, Howard L., 53 Passaic av., Passaic
Marini, D., 40 Henry st., Passaic
Markel, A., 320 Broadway, Paterson
Marsh, Elias J, 400 Van Houten st., Paterson
Masucci, A., 34 Ward st., Paterson
Matthews, L. M., 657 Main av., Passaic
Meier, William, Haskell
Meloney, Lester F., 156 2nd st., Clifton
Mendelsohn, D. H., 576 Broadway, Paterson
Meneve, A., 87 Bridge st., Paterson
Meyers, F. R., 80 Park av., Paterson
Michela, Luigi S., 206 Carroll st., Paterson
Mills, Alvah V., Lindsley rd., Little Falls
Missonelle, Wm, 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Morrill, James P., 310 Broadway, Paterson
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 245 Broadway, Paterson
Nesbit, Elizabeth, N. J. Tr'n'g School, Little Falls
Norval, Wm. A., 419 Main st., Paterson
Nye, Howard H., 174 Broadway, Paterson
O'Brian, D. M., 162 Lexington av., Passaic
O'Brien, J. H., 204 Madison pl., Passaic
Okin, I., 23 Passaic av., Passaic
Oram, Joseph H., 495 Broadway, Paterson
Pal, D. R., 32 Clark st., Paterson
Palma, N., 286 Broadway, Paterson
Payawall, J. L, 170 Broadway, Paterson
Pelusio, August N., 269 Carroll st., Paterson
Pernetti, A. M., 338 6th av., Paterson
Phelps, J. E., 203 Park av., Paterson
Piller, J., 245 Broadway, Passaic
Polizotti, J. L., 193 Park av., Paterson
Rauschenbach, Paul E., 223 Broadway, Paterson
Reading, H. E., 538 E. 29th st., Passaic
Reeves, E., 195 Lexington av., Passaic
Reynolds, Earl C., 657 Main av., Passaic
Reynolds, Harry C., 657 Main av., Passaic
Roemer, Jacob, 213 Broadway, Paterson
Roy, Jos. N., 95 17th av., Paterson
Ryan, John N., 158 Lexington av., Passaic
Salzman, Nathan, 306 Broadway, Paterson
Sanfacon, Thomas A., 82 Ward st., Paterson
Schultz, A. M., 379 Union av., Paterson
Scribner, Charles H., Hamburg Tyke, Paterson
Shapiro, L., 375 Broadway, Paterson
Shipee, David N., Midvale
Shulman, Abraham, 528 E. 29th st., Paterson
Sieveke, J., 106 Lexington av., Passaic
Simon, Morris L., 174 Washington pl., Passaic
Slaff, F., 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
Smith, C. W., Passaic
Smith, Leon A., 72 Grove st., Passaic
Spickers, William, 6 Church st., Paterson
Stark, M., 557 Broadway, Paterson
Stein, Harry M., 227 W. Broadway, Paterson
Stinson, Richard, 641 E. 18th st., Paterson
Surnamer, Isaac, 345 Broadway, Paterson
Sutherland, W. W., 320 Broadway, Paterson
Szymanski, J., 618 Main av., Passaic
Taber, L., 266 Van Houten st., Paterson
Tellman, D. H., 120 Lexington av., Passaic
Temple, Arthur H., 164 Jefferson st., Passaic
Terhune, Percy H., 171 Paulison av., Passaic
Todd, Francis H., 83 Auburn st., Paterson
Thorne, Wm. P., 30 Main st., Butler
Tomkins, Wm., Hohokus
Tuers, George E., 418 Park av., Paterson
Tweddel, George K., 156 Paterson st., Paterson
Vanderbeek, Andrew B., 174 Broadway, Paterson
Van Erde, Alfred H., 339 Laf'y'te av., Hawth'rne
Van Schott, G. J., Jr., 245 Lexington av., Passaic
Van Urk, Frederick T., 149 Lexington av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vosburg, Fred, 61 Passaic av., Passaic
Vreeland, Ralph J., 266 Van Houten st., Paterson
Walker, Harold G., Everett av., Wyckoff
Walton, Gordon G., 17 Church st., Paterson
Warren, D. E., 265 Gregory av., Passaic
Wassing, Hans, 695 Broadway, Paterson
Weinert, H. V., 162 Lexington av., Passaic
Westerhoff, P. A., Highland av., Midland Park
Widetsky, Alfred, 69 Hamilton av., Paterson
Wilkinson, Boyd E., 266 Van Houten st., Paterson
Willard, Harry S., 266 Van Houten st., Paterson
Williams, Hiram, 230 Lexington av., Passaic
Winters, Walter M., 288 Broadway, Paterson
Wolf, Israel J., 400 Broadway, Paterson
Wolfson, H., 324 Broadway, Paterson
Wry, Dean A., Passaic
Yates, John S., 414 Ellison st., Paterson

Associate Members

Gallo, James F., 32 Zabriskie st., Haledon
Scielzo, M. F., 777 Madison av., Paterson

Number of members and basis of representation, 202.

*Deceased.

SALEM COUNTY (17)

Society organized May 4, 1880. Meets second Wednesday in October, December, February and April. Social meeting in May. Annual meeting in October.

President

Hilliard, William Salem

Vice-President

Bramble, Halsey S., Elmer

Secretary and Treasurer

Green, D. W., Salem

Reporter

James, William H., Pennsville

Censors

James, W. H., Pennsville
Summerill, John M., Pennsgrove
Perry, Frank L., Woodstown

SALEM COUNTY—Continued

Bramble, Halsey S., Elmer
Davis, Richard M. A., Salem
Dunn, John S., Salem
Fleming, C. L., Pennsgrove
Green, David W., Salem
Hilliard, William T., Salem
Hummel, L. C., Salem
Hummel, L. H., Salem
James, William H., Pennsville
Mackes, C. L., Woodstown
Miller, Louis H., Woodstown
Perry, Frank L., Woodstown
Prigger, E. R., Pennsgrove
Sherron, Clifford M., Salem
Summerill, John M., Pennsgrove
Sutter, Harry F., Pennsgrove

Number of members and basis of representation, 16.

100 per cent paid up membership, Feb. 1, 1933.

SOMERSET COUNTY (18)

Society organized in May, 1816. Meets second Thursday in October, December, February, April, June and August. Annual meeting in October.

President

Flynn, T. H., Somerville

Vice-President

Mack, George L., Bound Brook

Secretary

Sferra, Alfred F. W., Bound Brook

Treasurer

Hegeman, Runkle F., Somerville

Reporter

Young, James L., Somerville

Censors

Brittain, E. G., Bound Brook
Meigh, Josiah, Bernardsville
Lawton, A. Anderson, Somerville

Adams, Rayford K., Skillman
Allis, Jere A., Basking Ridge
Anderson, John E., Neshanic
Barbour, Geo. E., Somerville
Beekman, John B., Bedminster
Borow, Benjamin, Bound Brook
Borow, Henry, Bound Brook
Borrow, Lewis, Bound Brook
Borrow, Maurice, Bound Brook
Brittain, Elmer G., Bound Brook
Cooper, J. Howard, East Millstone
Craig, Henry Augusta, Somerville
Crawford, John W., Bedminster
Dundon, A. H., N. Plainfield
Ely, Lancelot, Somerville
Field, Frank L., Far Hills
Flint, Edgar, Raritan
Flynn, Thomas H., Somerville
Francis, Adaline M., Somerville
Gray, W. B., North Plainfield
Halsted, Charles F., Somerville
Hegeman, Runkle F., Somerville
Henn, Louis D., N. Plainfield
Hird, Emerson F., Bound Brook
Husted, S. H., Neshanic
Kay, Clarence R., Peapack
Knight, Augustus S., Far Hills
Lawton, Anderson A., Somerville
Levy, A., Somerville
Long, William H., Somerville
Lovejoy, J., Bound Brook
*Mack, George L., Bound Brook
McConaughy, Francis, Somerville
Meigh, Josiah, Bernardsville
Pigott, Albert W., Skillman
Pogoloff, Samuel H., Manville
Renner, Dan Smith, Skillman
Robinson, John T., Bound Brook
Sferra, Alfred F. W., Bound Brook
Sherlock, Margaret E., Vinel'd State Sch'l, Vinel'd
Smalley, Mahlon C., Peapack
Stillwell, Aaron L., Somerville
Ten Eyck, John D., Franklin Park
Wallach, B., N. Plainfield
Wild, Frederick A., Bound Brook
Young, James L., Somerville
Zeglio, Peter J., North Plainfield

Associate Member

Voorhees, E. R., M.D.C., Somerville

Honorary Members

All Medical Officials and Medical Staff of the Veterans' Hospital in Millington.

Number of members and basis of representation, 46.

100 per cent paid up Feb. 1, 1933.

*Deceased.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Meets third Tuesday in October. Other meetings at convenience of members. Annual meeting in October.

President

Drake, L. B., Ogdensburg

Vice-President

Spencer, J. H., Newton

Treasurer

Pooley, Thomas R., Jr., Newton

Secretary

Wilbur, Frederick P., Franklin

Reporter

Morrison, Frederick H., Newton

Censors

Coleman, Joseph G., Hamburg
Smith, Warren H., Newton
Voorhees, Lamar, Newton

*Beatty, Enos E. B., Newton
Cole, Blase, Newton
Coleman, Joseph G., Hamburg

SUSSEX COUNTY—Continued

Drake, L B., Ogdensburg
Jacob, Albert N., Sparta
Johnson, George, Branchville
Landis, Edwin W., Stillwater
Morrison, Frederick H., Newton
Pellett, T. L., Hamburg
Pooley, Thomas R, Jr., Newton
Roy, Bert W., Sussex
Scott, F., Franklin
Smith, Warren H., Newton
Spencer, J. H., Newton
Spurgeon, D. L., Newton
Taylor, Edward, Franklin
Uptigrove, E. P., Vernon
Voorhees, Lamar, Newton
Wilbur, Frederick P., Franklin

Honorary Members

Cole, Martin H., Hainsville
Pellett, Jackson B., Hamburg

Transfers

White, Robert R., to Essex Co.

Number of members and basis of representation, 18.

100 per cent paid up. Feb. 1, 1933.

UNION COUNTY (20)

Society organized June 7, 1869. Meets second Wednesday of January, April, July and October. Annual meeting in October.

President

Stein, Emil, Elizabeth

Vice-President

Morris, Watson B., Millburn

Secretary

Horre, George W. H., Elizabeth

Treasurer

Hoover, Alden R., Elizabeth

Reporter

Shirrefs, Russell A., Elizabeth

Censors

Schlichter, Charles H., Elizabeth
Orton, George L., Rahway
Currie, N. W., Plainfield
Prout, Thos. P., Summit
Shangle, Milton, Elizabeth

Abel, Henri E., 345 Union av., Elizabeth
Ackerman, Arthur F., 129 Summit av., Summit
Addleman, Wm., 95 Center st., Garwood
Ard, Frank C., 604 Park av., Plainfield
Armstrong, L. B., 200 Ross pl., Westfield
Arthur, Frances, 156 Chilton st., Elizabeth
Babbitt, Hugh M., Jr., 503 Park av., Plainfield
Baker, Raymond Dewitt, 52 DeFor. av., Summit
Banker, George T., 1060 E. Jersey st., Elizabeth
Barr, A. H., 830 Wood av., Linden
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bensley, Maynard G., 129 Summit av., Summit
Birrell, R. G., 554 Westminster av., Elizabeth
Bishop, Carl, 604 Park av., Plainfield
Blair, T. D., 414 Park av., Plainfield
Bloch, Harry, 200 E. Jersey st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Roland P., 30 Springfield av., Cranford
Boozan, Wm. E., 1729 E. Jersey st., Elizabeth
Bowles, Harry H., 36 Woodland av., Summit
Boyes, J. G., 1326 Chetwood av., Plainfield
Breslow, A., 12 W. Milton av., Rahway
Brokaw, Chris. A., 1405 North av., Elizabeth
Brown, L. Greeley, 173 Madison av., Elizabeth
*Buck, Adrian O., 19 Pingry pl., Elizabeth
Bunting, P. DuBois, 712 N. Broad st., Elizabeth
Burnett, Thos. F., 151 Court st., Elizabeth
Burritt, Norman W., 30 Beachwood rd., Summit
Butenas, Jos. J., 300 1st av., Elizabeth
Byington, R., 261 Springfield av., Summit
*Campus, Ellis, 612 W. Front st., Plainfield
Cantini, Raphael, 934 Plainfield av., Plainfield
Card, Charles F., 100 W. Milton av., Rahway
Cardinale, Pasquale, 542 Eliz. av., Elizabeth
Carlon, Edward J., 20 Jaques av., Rahway
Carmen, John H., 602 Crescent av., Plainfield
Casilli, A. R., 618 Newark av., Elizabeth
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth
Chapman, O. P., 270 Morris av., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Cole, Walter H., 537 Westfield av., Elizabeth
Communale, A. R., 63 Irving st., Rahway
Corbusier, H. D., 612 Park av., Plainfield
Cornwell, F. W., 207 E. 7th st., Plainfield
Cregar, Peter B., 420 Grant av., Plainfield
Cronin, Francis J., 730 South st., Elizabeth
Currie, Norman W., 508 Central av., Plainfield
Daron, Simeon, 405 Westminster av., Elizabeth
Davidson, E. Norwell, 102 Elm st., Linden
Davis, F. C., 129 Summit av., Summit
Davis, Stanton H., 420 Park av., Plainfield
Day, Willis B., 154 E. 7th st., Plainfield
DeCesare, F. D., 500 Walnut st., Roselle
Decker, Charles T., 510 Prospect av., Westfield
DeFreitas, Clement, 115 W. 4th st., Plainfield
Dengler, H. P., Morris av., Springfield
Dennin, Jos. W., 308 Chestnut st., Roselle
Disbrow, G Ward, 126 Mountain av., Summit
Draggett, E. Hugh, 441 W. Front st., Plainfield
Drury, Alfred J., 150 2d av., East, Roselle Park
Durrah, Fred F., 310 Plainfield av., Plainfield
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Eason, S. W., 48 DeForest av., Summit
*Eaton, Alvin R, 116 W. Jersey st., Elizabeth
Ferguson, Chas., 435 Westminster av., Elizabeth
Fitch, Thomas, 744 Watchung av., Plainfield
Fleeter, Meyer A., 893 Magie av., Elizabeth
Fordyce, C. P., P. O. Box 322, Westfield
Foster, Frank L., 320 Springfield av., W. Cranf'd
Franklin, Jos. E., 127 Westfield av., Elizabeth
Friedburg, Geo. H., 1139 E. Broad st., Elizabetn
Frohwein, Ida H., 119 Morristown rd., Elizabeth
Funk, Joseph, 615 Elizabeth av., Elizabeth
Galloway, George E., 109 Milton av., Rahway
Geary, Paul, 706 Park av., Plainfield
Gelber, Isaac, 30 Morris av., Union
Gerendasy, J., 225 E. Jersey st., Elizabeth
Gibbs, Alice S., 339 Union av., Elizabeth
Giglio, A. S. V., 626 Elizabeth av., Elizabeth
Gilpin, Friend B., Cranford
Gittelman, Morton, 1028 E. Jersey st., Elizabeth
Glaser, E., 218 Marshall st., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glasston, H. M., 628 N. Wood av., Linden
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, H. B, 555 S. Broad st., Elizabeth
Goldstein, H. H., 1065 E. Jersey st., Elizabeth

UNION COUNTY—Continued

Goodrich, S. L., St'n'rd Oil Co. of N. J., Jer. City
Gorezyea, A. G., 538 S. Broad st., Elizabeth
Green, James S., 463 N. Broad st., Elizabeth
Gregory, R. A., 121 E. 7th st., Plainfield
Griesmier, Zadoc L., 1143 E. Jersey st., Elizabeth
Guidi, Guido M., 212 Christine st., Elizabeth
Hallock, W. J., Berkeley Height, Summit
Hanrahan, Jas. M., 1144 E. Broad st., Elizabeth
Harrison, Joseph B., 302 E. Broad st., Westfield
Haseltine, S. L., 410 Westminster av., Elizabeth
Higgins, T. F., 146 Reid st., Elizabeth
Hnat, Frederick, 450 Rahway av., Elizabeth
Hoffman, C. A., 24 Sleepy Hollow Lane, Plainfield
Holmes, Grace A., 1077 E. Jersey av., Elizabeth
Hoover, A. R., 5 Prince st., Elizabeth
Horre, Geo. W. H., 204 W. Jersey st., Elizabeth
Hubbard, Harry H. V., 121 E. 7th st., Plainfield
Hughes, Frederick J., 706 Park av., Plainfield
Imbleau, J. E. L., Morris av., Union
Iserman, M., 376 Elmora av., Elizabeth
Jackson, G. H., 1030 Pine st., Union
Johnson, Harold F., 915 Kensington, Plainfield
Jones, Lewis H., 139 Grant av., Roselle Park
Kapp, Carl G., 410 Westminster av., Elizabeth
Kemper, Harry T., 225 Orchard st., Elizabeth
Kieney, C. B., 137 Summit av., Summit
Kinch, Fred A., 267 E. Broad st., Westfield
Knauer, George, 930 Elizabeth av., Elizabeth
Knepper, Orcena F., 149 Crescent av., Plainfield
Konzelman, Henry J., 50 King st., Hillside
Kralikauckas, Jos. K., 164 Park pl., Elizabeth
Krans, Clara DeH., 920 Park av., Plainfield
Krans, Edw. S., 920 Park av., Plainfield
Kushner, Alexander, 48 Jaques av., Rahway
Labow, Joseph J., 1050 E. Jersey st., Elizabeth
Laird, George S., 127 Central av., Westfield
*Lamson, Wm. J., 120 Summit av., Summit
Lance, E. W., 98 W. Milton av., Rahway
Larrabee, C. H., 30 Beechwood rd., Summit
Lathrop, Frederick W., 507 Park av., Plainfield
Lawrence, Wm., Jr., 129 Summit av., Summit
Leggett, L. H., 330 E. Broad st., Westfield
Leggett, Thos. H., Jr., 706 Park av., Plainfield
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 1072 North av., Elizabeth
Lilien, M. M., 162 Gruman av., Hillside
Livengood, Horace R., 587 Westminster av., Eliz.
Lodas, George, 1141 E. Jersey st., Elizabeth
Losada, Camella A., 19 Prospect st., Summit
Lowell, M. E., 434 Summit av., Westfield
Lufburrow, C. B., 411 W. Front st., Plainfield
Malatesta, C. S., 741 Kingston av., Plainfield
McCallion, W. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1435 Mapes av., Hillside
McElhinney, Dennis R., 110 W. Jer. st., Elizabeth
McGinn, W. J., Front st., Scotch Plains
Mentzer, C. A., 42 Hollywood av., Hillside
Miller, Robt. M., 382 Springfield av., Summit
Moister, Roger W., 30 Beachwood rd., Summit
Montfort, Robt. J., 1051 E. Jersey st., Elizabeth
Moress, Edward J., 1501 Maple av., Hillside
Morris, Thos. M., 503 Park av., Plainfield
Morris, Watson B., 193 Morris av., Millburn
Mravlag, Victor, 1064 E. Jersey st., Elizabeth
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Herschel S., 130 Grant av., E. R's'le P'k
Newman, Louis G., 316 E. Broad st., Westfield
Nittoli, R. N., 660 E. Jersey st., Elizabeth
Oakes, A. E., 1158 Mary st., Elizabeth
O'Brion, D. J., 197 Spring st., Portland, Me.
Orton, George Lee, 98 Elm st., Rahway
Paulson, A. M., 160 E. 7th st., Plainfield
Perkins, J. L., 16 Alden st., Cranford
Peters, Richard C., 923 Park av., Plainfield
Phelan, W. F., 124 Chilton st., Elizabeth
Prout, Thos. P., 19 Prospect st., Summit
Quinn, Stephen T., 1143 E. Jersey st., Elizabeth
Radding, M. B., 321 Elmira av., Elizabeth
Ramsey, M. E., 435 E. Broad st., Westfield
Randolph, John M., 131 Main st., Rahway
Rathbone, T. H., 129 Summit av., Summit
Rayne, J. Edw., 116 Cherry st., Elizabeth
Reich, Jerome J., 1420 Maple av., Hillside
Reiner, Jacob, 811 N. Broad st., Elizabeth
Ripps, Maurice L., 331 Elmora av., Elizabeth
Robertson, Grace M., 820 2d pl., Plainfield
Robinson, Moe, 1014 E. Grand st., Elizabeth
Runnells, J. E., Bonnie Burns San., Scotch Plains
Sadoff, Joseph, 116 Elmora av., Elizabeth
Salvati, Leo H., 224 Walnut st., Westfield
Schenk, Jos. R., 318 W. 7th st., Plainfield
Schilling, A. B., 727 Jefferson av., Elizabeth
Schlichter, Chas. H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 414 Park av., Plainfield
Sell, Frederick W., 113 Commerce st., Rahway
Seybold, Arthur D., 302 E. 7th st., Plainfield
Seymour, Geo. A., 253 Orchard st., Elizabeth
Shangle, Milt A., 34 Prince st., Elizabeth
Shirrefs, Rus. A., 57 Broad st., Elizabeth
Simon, Henry, 423 Elizaeth av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Stanton, Nath. B., 734 Park av., Plainfield
Staub, E. Milton, 531 E. Broad st., Westfield
Steele, Stephen, 500 Wood av, Linden
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., Elizabeth
Stein, Isadore, 210 Elizabeth av., Elizabeth
Stein, Martin H., 163 Second st., Elizabeth
Stephenson, G. A., Jersey City Hosp., Jersey City
Stern, Arthur, 224 E. Jersey st., Elizabeth
Steuart, David T., 6 Norwood ter., Summit
Strelinger, Edward A., 414 Eliz. av., Elizabeth
Strom, A., 410 W. 7th st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Thomas, Mary Louise, 1 Euclid av., Elizabeth
*Thompson, R. J., 128 E. Grant av., Roselle Park
Tidaback, John D., 447 Springfield av., Summit
Turner, Wm F., 519 Magie st., Elizabeth
Vail, Jas. Lindley, 24 Holly st., Cranford
Van Horn, Alfred F., 514 Central av., Plainfield
Vinciguerra, Michael, 410 Westminster av., Eliz.
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Wade, Simeon F., 555 Newark av., Elizabeth
Wagner, Otto, 111 Stiles av., Elizabeth
Walsh, Thomas J., 335 So. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Warncke, F. H., 523 Westfield av., Elizabeth
Wegryn, Louis S., 250 First av., Elizabeth
Weigel, Edgar Wm., 970 Park av., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Weissman, J. C., 1050 E. Jersey st., Elizabeth
Williams, Frank A., 324 W. Jersey st., Elizabeth
*Wilson, Norton L., 410 W'tm'ster av., Elizabeth
Woody, McIver, 19 Pingry pl., Elizabeth
Young, Franklin C., 120 Summit av., Summit
Yuckman, Wm., 224 W. Jersey st., Elizabeth
Zeitlin, H. H., 943 N. Ward st., Linden

Resigned

Maged, A. J.
Upham, C. H. E.

Transfers

Weissman, J. C., to Essex County

Number of members and basis of representation, 219.

100 per cent paid up membership, Feb. 1, 1933
*Deceased.

WARREN COUNTY (21)

Society organized February 15, 1826. Meets second Tuesday of January, April, July and October. Annual meeting in October

President
Wing, Raymond, Bairstown

Vice-President
Krausz, Emory, Phillipsburg

Secretary
Hackett, L. W., Washington

Treasurer
Cummins, G. Wyckoff, Belvidere

Reporter
Smith, Chas. B., Washington

Censors
Bossard, H. B., Phillipsburg
Lyon, C. H., Phillipsburg

Allen, William C., Blairstown
Baldauf, Herman, Belvidere
Bloom, Lawrence H., 8 Market st., Phillipsburg
Bossard, Henry B., Phillipsburg
Brasefield, Edgar N., Phillipsburg
Cummins, G. Wyckoff, Belvidere
Curtis, Frank W., Stewartsville
Gordon, William, Blairstown
Hackett, Leon W., Washington
Hoagland, Louis B., Oxford
Krauss, Emory, Phillipsburg
La Riew, Fred J., Washington
Lyon, C. H., Phillipsburg
Lyon, C. V., Phillipsburg
McKinstry, Frank P., Washington
Pursell, William Dana, Phillipsburg
Shimer, Floyd A., Phillipsburg
Skinner, William F., Washington
Smith, Charles B., Washington
Varney, W. H., Washington
Vail, Wm. Penn, Blairstown
Wing, Raymond, Blairstown
Zuck, A. C., Washington

Number of members and basis of representation, 23.

100 per cent paid up Feb. 5, 1933.
*Deceased.

SUMMARY

Total Membership

ATLANTIC	103
BERGEN	191
BURLINGTON	52
CAPE MAY	21
CAMDEN	139
CUMBERLAND	49
ESSEX	726
GLOUCESTER	34
HUDSON	420
HUNTERDON	25
MERCER	160
MIDDLESEX	122
MONMOUTH	80
MORRIS	86
OCEAN	21
PASSAIC	202
SALEM	16
SOMERSET	46
SUSSEX	18
UNION	219
WARREN	23
	2750

Counties reporting as many members as were listed in the Official List of 1932 are carried in this column as being 100 per cent paid up.

ATLANTIC
BERGEN
CAPE MAY
CAMDEN
CUMBERLAND
ESSEX
GLOUCESTER
HUNTERDON
MERCER
MIDDLESEX
MONMOUTH
MORRIS
SALEM
SOMERSET
SUSSEX
UNION
WARREN

New Members

Only those listed who have paid 1933 dues.

ATLANTIC	5
BERGEN	17
BURLINGTON	3
CAPE MAY	1
CAMDEN	7
CUMBERLAND	3
ESSEX	30
GLOUCESTER	3
HUDSON	20
HUNTERDON	2
MERCER	3
MIDDLESEX	11
MONMOUTH	3
MORRIS	8
OCEAN	0
PASSAIC	5
SALEM	0
SOMERSET	0
SUSSEX	1
UNION	9
WARREN	4
	135

Number of deaths during the year, 39.

Number of Associate Members elected in all the Component Societies, 74

Comparison with 1932

Members on Official List, Feb. 5, 1932.....2612
Member on Official List, Feb. 5, 1933.....2750

New members elected in 1931-32.....134
New members elected in 1932-33.....135

J. BENNETT MORRISON,
Secretary.

An Alphabetical List of the Members of the Medical Society of New Jersey

Compiled May, 1933

The figures in paranthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.
* Deceased.

Abel, Henri E., 345 Union av., Elizabeth (20)
Abey, W. J. H., 23 N. Del. av., Pennington (11)
Abrams, A. B., 668 Clinton av., Newark (7)
Ackerman, Arthur F., 129 Summit av., Summit (20)
Ackerman, Edward, Dover (14)
Ackerman, James F., 1010 Grand av., Asb. P'k (13)
Ackley, D. B., 21 No. Clinton av., Trenton (11)
Adams, Charles F., 34 W. State st., Trenton (11)
Adams, Flora, Hackensack (2)
Adams, John K., 3 Prospect st., East Orange (7)
Adams, Rayford K., Skillman (18)
Adams, Samuel, 29 Highland av., Jersey City (9)
Addleman, Wm., 95 Centre st., Garwood (20)
Adelman, Benj. B., 190 Clinton av., Newark (7)
Africano, J. V., 4246 Hudson Blvd., Union City (9)
Africano, S., 526 15th st., Union City (9)
Ainsley, H. Bryson, 246 Union st., Jersey City (9)
Albano, Joseph, 535 No. 7th st., Newark (7)
Albee, Geo. C., 219 S. Orange av., S. Orange (7)
Albright, Louis F., Jersey av., Spring Lake (13)
Alexander, Hugo, 1029 Garden st., Hoboken (9)
Alexander, Samuel, Park Ridge (2)
Alexander, W. G., 48 Webster pl., Orange (7)
Allaben, Anna, 165 South st., Morristown (14)
Allan, James S., 49 Prospect st., E. Orange (7)
Allan, W. J., 144 Harrison st., E. Orange (7)
Allen, Frederick M., Morristown (14)
Allen, G. Herbert, 181 Roseville av., Newark (7)
Allen, I. L., 521 Palisade av., Union City (9)
Allen, J. M., 377 Main av., Passaic (16)
Allen, W. B., Englewood (2)
Allen, William C., Blairstown (21)
Alling, Frederick A., 15 Washington st., Newark (7)
Allis, Jere A., Basking Ridge (18)
Allman, David B., 104 St. Charles pl., Atl. City (1)
Alpert, Edward, 661 Jersey av., Jersey City (9)
Altschul, Frank J., 128 Garfield av., L. Branch (13)
Alter, Nicholas M., 406 Fairmount av., Jer. City (9)
Anderson, John E., Neshanic (18)
Anderson, J. F., 195 College av., N. Brunswick (12)
Anderson, Richard D., Burlington (3)
Anderson, R. M., Hackensack (2)
Andrews, Clarence L., 1616 Pacific av., Atl. C'y (1)
Angelillis, P., Hackensack (2)
Angelo, Jos. A., 1190 P't'rs'n Plank rd., Secaucus (9)
Antonius, N. A., 27 W. Market st., Newark (7)
Anuario, Chas. B., 283 S. Centre st., Orange (7)
*Applegate, A. T., Englishtown (13)
Applegate, E. T. R., 1125 Greenwood, Trenton (11)
Applegate, G. T., 71 Livingston st., N. Br'sw'k (12)
Appleton, Ralph, Farmingdale (13)
Applestein, Robert, 569 E. State st., Trenton (11)
Appold, Geo. D., Bergenfield (2)
Apter, A. H., 669 Broadway, Paterson (16)
Ard, Frank C., 604 Park av., Plainfield (20)
Areson, Wm. H., 153 Belvu. av., U. Montclair (7)
Aria, Michael, 31 Glenwood av., Jersey City (9)
Arlitz, Wm. J., 107 Newark st., Hoboken (9)
*Armstrong, Alexander, White Haven, Pa. (11)
Armstrong, L. B., 200 Ross pl., Westfield (20)
Armstrong, R. R., 144 Pen'gton av., Passaic (16)
*Armstrong, Samuel E., Rutherford (2)
Aronis, H. R., 239 E. Hanover st., Trenton (11)
Arthur, Francis, 156 Chilton st., Elizabeth (20)
*Arthur, Francis M., Hamilton Square, Trenton (11)
Ash, Arthur F., 710 Blvd. East, Weehawken (9)
Ash, Frank W., 108 Carroll st., Paterson (16)
Ashcraft, Samuel F., Mullica Hill (8)
Asher, Maurice, 186 Clinton av., Newark (7)
Ashley, H. H., 192 W. State st., Trenton (11)
Aszody, Paul, 340 Waverly av., Newark (7)
Atkinson, A. W., 423 E. State st., Trenton (11)
Atkinson, Jas. W., 485 S. Maple av., Glen Rock (16)
Atwood, Edw. A., 360 Park av., Paterson ((16)
Auriemma, Michael, 419 Adams st., Hoboken (9)
Avery, Phillip S., Mid. Gen. Hosp., New Br'sw'k (12)
Avidan, Maurice S., 30 Stratford pl., Newark (7)
Axford, W. Homer, 840 Blvd., Bayonne (9)
Axilrod, Maurice H., 2620 Pacific av., Atl. City (1)

Associate Members

Alford, Ralph I., 9 N. Mountain av., Montclair (7)
Applebaum, I. L., 304 Fairmount av., Newark (7)

Bachmann, Wm., 87 Hillcrest ter., E. Orange (7)
Babbitt, Hugh M., Jr., 503 Park av., Plainfield (20)
Bacon, Mary, Bridgeton (6)
Baechler, Jules, 439 16th st., W. New York (9)
Baeseman, R. W., 501 Grant av., Asbury Park (13)
Bagg, Linus W., 31 Lincoln Park, Newark (7)
Bahnson, Conrad M., 170 Bowers st., Jer. City (9)
Bailey, Wilson G., 512 Broadway, Camden (4)
Baird, T. M., 124 Grand pl., Arlington (7)
Baker, August L. L., Dover (14)
Baker, Charles F., 198 Clinton av., Newark (7)
Baker, Elsworth F., State Hosp, Marlboro (13)
Baker, Raymond Dewitt, 52 DeFor. av., Summit (20)
Baker, Hugh H., Vineland (6)
Baker, Maurice E., 1149 Kaighn av., Camden (4)
Baketel, S. H., Jersey City (2)
Baldauf, Herman, Belvidere (21)
Baldwin, Samuel H., 626 Clinton av., Newark (7)
Ballinger, Reeve L., 659 Kearny av., Arlington (9)
Balze, H. R., Leonia (2)
Banach, Leon, 2747 Boulevard, Jersey City (9)
Banker, George T., 1060 E. Jersey st., Elizabeth (20)
Banks, Winifred D., 6 N. Munn av., E. Orange (7)
Barb, K. B., Kaighn & Princess avs., Camden (4)
Barbarito, Wm. N., 2671 Boulevard, Jersey City (9)
Barbour, Geo. E., Somerville (18)
Barbash, Samuel, 1902 Pacific av., Atlantic City (1)
*Bardsley, C. A., Park av., Laurel Springs (4)
Barishaw, S. B., 5 Bentley av., Jersey City (9)
Barkhorn, Chas. W., 223 Roseville av., Newark (7)
Barkhorn, Henry C., 45 Johnson av., Newark (7)
Barnes, William J., Englewood (2)
Barnshaw, Harold M., 2626 Federal st., Camden (4)
Barr, A. H., 830 Wood av., Linden (20)
Barr, Joseph, 975 Madison av., Paterson (16)
Barrett, A. F., 835 Montgomery st., Jersey City (9)

Barrett, Jos. F., 230 Parker st., Maplewood (7)
Barrett, Wesley J., 517 Cooper st., Camden (4)
Barrows, A. M., 440 Hamilton av., Trenton (11)
Barrows, Victor I., Pitman (8)
Barry, R. G., 897 W. State st., Trenton (11)
Bartlett, Clara K., 4301 Atl. av., Atlantic City (1)
Bartlett, W. M., 180 Bergen av., Jersey City (9)
Bass, Rose D., 222 Lyons av., Newark (7)
Basset, Lavern C., 320 N'wm'rket rd., Dunellen (12)
Bassett, N. L., 117 S. Illinois av., Atlantic City (1)
Bauer, Harry W., Palmyra (3)
Baum, Felix, 31 Lincoln Park, Newark (7)
Baum, Samuel, 10 Osborne ter., Newark (7)
Beairsto, E. B., 178 W. State st., Trenton (11)
Berardinelli, C. G., 32 Eighth av., Newark (7)
*Beatty, Enos E. B., Newton (19)
Beaver, Jennie Dean, 8 Oliphant Pk., Morrist'n (14)
Becker, G. L., 646 E. 28th st., Paterson (16)
Becker, Fred C., 620 Benson st., Camden (4)
Becker, Fred W., 14 Clinton pl., Newark (7)
Becket, Geo. C., 350 Springdale av., E. Orange (7)
Beekman, Jesse H., Sayreville (12)
Beekman, John B., Bedminster (18)
Behrens, Herman, 312 Webster st, Jersey City (9)
Beideman, Casper M., 5 W. Maple av., M'ch'tv. (4)
Beir, I. R., Haverford Apts., Atlantic City (1)
Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
Beling, Chris. C., 109 Clinton av., Newark (7)
Belford, R. J., 1st Nat Bank Bldg., Princeton (11)
Bell, J. Finley, Englewood (2)
Bell, Thomas, 340 Belmont av., Newark (7)
Bellak, Ellis R., Leesburg (6)
Bellis, Horace D., 437 E. State st., Trenton ((11)
Belting, Arthur W., P. O. Box 68, Trenton (11)
Ben-Asher, Sol., 260 Bergen av., Jersey City (9)
Bender, Max, 327 23rd st., Union City (9)
Bender, Theo. T., 666 Broadway, Paterson (16)
Benedict, A. C., 121 Irvington av., S. Orange (7)
Bengelsdorf, A., 29 Clinton pl., Newark (7)
Benjamin, H. C., 59 Crescent av., Jersey City (9)
Bennett, Samuel D., Millville (6)
Bennett, W. F., Essex Co. Sanatorium, Verona (7)
Bensley, Maynard G., 129 Summit av., Summit (20)
Bentley, D. F., Jr., 403 Cooper st., Camden (4)
Berardinelli, C. G., 92 8th av., Newark (7)
Berg, S., 530 Central av., Newark (7)
Bergen, Marshall, 273 Bergen av, Jersey City (9)
Berger, Harry, 921 Clinton av., Trenton (11)
Berger, W. A., 268 N. 7th st., Newark (7)
Bergin, J. V., 315 Broadway, Paterson (16)
Bergman, M. W., 825 S. 10th st., Newark (7)
Berke, R. N., Hackensack (2)
Berkow, Samuel G., 138 Market st., P. Amboy (12)
Berlin, Joseph I., 9 Gifford av., Jersey City (9)
Berman, Jacob J., 409 Market st., Trenton (11)
Berman, Robert H., 286 Roseville av., Newark (7)
Berner, David, 2817 Pacific av., Atlantic City (1)
Beshlian, Hagop K., 7 Lee pl., Paterson (16)
Beyer, Othmar J., 42 Laurel av., Irvington (7)
Beyer, W., Jr., 38 Grand av., Englewood (2)
Bianchi, Angelo R., 104 7th av., Newark (7)
Bickner, A. W., Jr., Rutherford (2)
Bien, Frank A., 999 Clinton av., Newark (7)
Bierach, Jules, Toms River (15)
Bigelow, N. S., 117 Irvington av., S. Orange (7)
Binder, Joseph, 422 Bergen av., Jersey City (9)
Binder, Joseph, 149 Garfield av., Long Branch (13)
Bingham, A. W., 144 Harrison av., East Orange (7)
Bird, Frank L., Netcong (14)
Birdsall, Clarence, 3 Small pl., Caldwell (7)
Bircley, M. Franklin, 361 15th av., Paterson (16)
Birrell, R. G., 554 Westminster av., Elizabeth (20)
Bishop, Carl, 604 Park av., Plainfield (20)
Bissett, John V., 29 Hawthorne av., E. Orange (7)
Bitten, Robert M., 33 Romaine av., Jersey City (9)
Black, Alan B., Clarksboro (8)
Blackburne, G., 490 Central av., Newark (7)
Blackwell, Enoch, Trenton Trust Bldg., Trenton(11)
Blair, T. D., 414 Park av, Plainfield (20)
Blaisdell, C. Byron, 48 Norwood av., L. Branch (13)
Blakey, A. P., 475 Jersey av., Jersey City (9)
Blampin, Winifred A., Galen Hall, Atlantic City (1)
Blanchard, Charles L., 26 E. Blackwell st., Dover(14)
Blanchard, Kenneth, 25 S. Munn av., E. Orange (7)
Blanchard, O. R., 37 Clinton av., Jersey City (9)
Blaugrund, Samuel, 190 W. State st., Trenton (11)
Blauvelt, Grace B., Ridgewood (2)
Bleasby, C., Garfield (2)
Bleick, Theodore E., 61 Van Ness pl., Newark (7)
Bleick, Wm. D., 583 Prospect av., Maplewood (7)
Blenkle, V. A., Teaneck (2)
Bloch, Harry, 200 E. Jersey st., Elizabeth (20)
Block, Marcus T., 177 Bloomfield av., Newark (7)
Bloom, Lawrence H., 8 Market st., Phillipsb'g (21)
Blum, Jos. M., 128 Mill st., Trenton (11)
Blumberg, Jack, 504 Westminster av., Elizabeth(20)
Blythe, Roland P., 30 Springfield av., Cranford (20)
Bohl, Louis J., 320 Broadway, Paterson (16)
Boker, Emory, 544 Springfield av., Newark (7)
Bongiorno, Henry D., 516 Paterson st., P't'rs'n (16)
Bono, J., Northvale (2)
Bonynge, H. A., 123 Prospect st., Ridgewood (16)
Bookrajian, Edw. N., 5436 Hudson Blvd.,N.B'rg'n(9)
Bookstaver, B. F., Teaneck (2)
Boothby, I. R., Clinton (10)
Boozan, W. E., 1729 E. Jersey st., Elizabeth (20)
Borow, Benjamin, Bound Brook (18)
Borow, Henry, Bound Brook (18)
Borrow, Louis, Bound Brook (18)
Borrow, Maurice, Bound Brook (18)
Borshaw, Hyman, 108 Bentley, Jersey City (9)
Bortone, Frank, 2765 Boulevard, Jersey City (9)
Bosch, T., Midland Park (2)
Bosch, C. C. F., Dumont (2)
Boselli, Emile H., 614 15th st., Union City (9)
Bossard, Henry B., Phillipsburg (21)
Bostwick, Delazon S., Bridgeton (6)
Bostwick, Wallace R., 56 Church st., Montclair (7)
Botti, John A., 236 Summit av., Jersey City (9)
Botbyl, B. W., 927 Madison av., Paterson (16)
Boulden, George P., Cranbury (12)
Bowen, Horace, 2787 Boulevard, Jersey City (9)
Bowles, Harry H., 36 Woodland av., Summit (20)
Bowman, A. K., 272 Nassau st., Princeton (11)
Bowyer, Frank F., 50 Gifford av., Jersey City (9)
Boyd, John, East Front st., Red Bank (13)
Boyer, Charles G., Annandale (10)
Boyes, J. G., 1326 Chetwood av., Plainfield (20)
Boylan, Lawrence B., 630 Main st., Paterson (16)
Boyle, Thomas P., 2 Gouverneur st., Newark (7)
Boysen, Theophilus, 100 Phila. st., Egg Harbor (1)
Brackett, Eliz. R., 349 Franklin av., Nutley (7)
Bradford, Stella S., 16 Seymour av., Montclair (7)
Bradshaw, John H., 27 High st., Orange (7)
Brady, Thomas S., 678 Ave. C, Bayonne (9)
Brady, Wm. A., 403 46th st., Union City (9)
Brakeley, Elizabeth, 21 Trinity pl., Montclair (7)
Bramble, Halsey S., Elmer (17)
Branch, W. Harold, 190 Duncan av., Jersey City (9)
Brandenberg, L. W., 4620 Boulevard, Union City (9)
Branin, Howard S., Millville (6)
Brasefield, Edgar N., Phillipsburg (21)
Brauer, Selig, 242 Bergen av., Jersey City (9)
Braun, Gus A., 391 Bergen st., Newark (7)
Braunstein, S. C., 424 13th st., W. New York (9)
Braunstein, Wm. P., 831 Blvd., E. Weehawken (9)
Bregman, Alexander, Edgewater (2)
Brennan, A. T. V., Tenafly (2)
Brennan, Chas. L. S., 19 S. B'way, Gloucester (4)
Brennan, John P., 306 Cooper st., Camden (4)
Brennoch, Thos. McG., 3 Webster av., Jer. City (9)
Breslow, A., 12 W. Milton av., Rahway (20)
Breslow, S., 111 Market st., Perth Amboy (12)
Brevoort, Henry H., Main st., Lodi (16)
Brewer, David R., 536 Market st., Gloucester (4)

Brewer, William, Woodbury (8)
Brick, G. J., 43 Cottage st., Jersey City (9)
Brien, William M., 449 Main st., Orange (7)
Briggs, H., 207 Harrison st., E. Orange (7)
Brim, Anne J. S., 83 Lincoln Park, Newark (7)
Brittain, Elmer G., Bound Brook (18)
Britton, Roland L., 336 N. Main st., Mays L'nd'g (1)
Broadnax, Mary E., 83 Lincoln Park, Newark (7)
Brodkin, Eva T., 365 Osborne ter., Newark (7)
Brodkin, H. A., 365 Osborne ter., Newark (7)
Brodowski, J. J., 554½ Jer. av., Jersey City (9)
Brody, M. J., 84 Bayard st., New Brunswick (12)
Broeser, H. V., H'b'k'n B'k for Sav'gs., Hoboken (9)
Brokaw, Chris. A., 1405 North av., Elizabeth (20)
Brooke, C. R., 1136 Broad st., Newark (7)
Brooke, William W., 915 Ave. C, Bayonne (9)
Brooks, George M., Cape May Court House (5)
Brooks, S. S., 62 12th av., Paterson (16)
Bromberg, Charles B., Passaic (16)
Brophy, Francis X., 705 Bergen av., Jer. City (9)
Brotman, Morton M., 90 Avon av., Newark (7)
Brown, Chester R., 22 Midland av., Arlington (7)
Brown, C. T., Prudential Ins. Co., Newark (7)
Brown, E. V., 585 Kearny av., Arlington (7)
Brown, F. L., 67 Livingston av., N. Brunswick (12)
Brown, Harvey S., Freehold (13)
Brown, J. L., Grantwood (2)
Brown, Kenneth, Asbury av., Asbury Park (13)
Brown, Lewis W., 15 Fulton st., Newark (7)
Brown, L. Greeley, 173 Madison av., Elizabeth (20)
Brown, Richard J., 105 Ridgewood rd., S. Orange (7)
Browning, W. K., 120 N. Centre st., M'rch'ntv'le (4)
Browning, Wm. J., 134 N. Centre st., M'rch'ntv'le (4)
Brouwer, Frank, Toms River (15)
Bruder, A. J., 344 Fairmont av., Jersey City (9)
*Bruington, S. S., 115 Spruce st., Newark (7)
*Buck, Adrian O., 19 Pingry pl., Elizabeth (20)
Buckley, J. L., 684 Franklin av., Nutley (7)
Buckley, P. T., Bogota (2)
Buermann, Robert, Lakewood (15)
Buermann, William, 9 Lincoln Park, Newark (7)
Bull, Louis M., 92 Heller Prkwy., Newark (7)
Bull, W. J., 92 Heller Parkway, Newark (7)
Bulwinkle, Frederick, Atlantic Highlands (13)
Bumsted, Clarence, 235 Grafton av., Newark (7)
Bunn, F. C., 30 Hillyer st., Orange (7)
Bunnell, Frederick N., Barnegat (15)
Bunting, P. DuB., 712 N. Broad st., Elizabeth (20)
Burbank, H. E., Lyndhurst (2)
Burke, Stephen E., 212 First av., Newark (7)
Burne, John J., 17 Gould av., Newark (7)
Burnham, L., Tenafly (2)
Burnett, Chas. B., Main st., South River (12)
Burnett, Thos. F., 151 Court st., Elizabeth (20)
Burns, Edward L., 269 Broad st., Newark (7)
Burns, G. C. H., Tenafly (2)
Burpeau, Wm. P., 17 Wayne av., E. Orange (7)
Burritt, Norman W., 30 Beachw'd rd., Summit (20)
Busansky, Samuel T., New Lisbon (3)
Bush, Archer C., 40 Union av. Montclair (7)
Bush, Ralph K., 131 E. Park av., Merchantville (4)
Busch, Herman, 38 Johnson av., Newark (7)
Busicco, P. S., Englewood (2)
Butcher, Charles, Heisleville (6)
Butenas, Jos. J., 300 1st av., Elizabeth (20)
Butler, Eustiec C., 249 Bloomfield av., Caldwell (7)
Butler, Samue' S., 1100 Kaigh'n av., Camden (4)
Butler, Vincent P., 921 Bergen av., Jersey C'y (9)
Butterfield, A. A., P's'c Nat'l Bk. Bldg., Passaic (16)
Buvinger, Chas. W., 50 Wash'g'n st., E. Orange (7)
Buzby, B. Franklin, 414 Cooper st., Camden (4)
Byer, C. W., Rutherford (2)
Byington, R., 261 Springfield av., Summit (20)

ASSOCIATE MEMBERS

Barone, Francis A., 175 Fulton st., Jersey City (9)
Bergen, Marshall, 273 Bergen av., Jersey City (9)
Blumberg, A. W., 996 Broad st., Trenton (11)
Buckley, Richard T., Peddie School, Hightstown (11)
Burroughs, Edmund W., 701 W. State st., Tr'nt'n(11)
Cacciarelli, Robt. A., 517 Roseville av., Newark (7)
Cahill, L. A., 353 Lafayette st., Newark (7)
Caldroney, T. L., Ridgefield Park (2)
Caldwell, J. A., 45 S. Mountain av., Montclair (7)
Callery, Wm., 4 Columbia ter., Weehawken (9)
Calvin, Charles, 80 Commerce st., Perth Amboy (12)
Camche, L. J., 458 Hawthorne av., Newark (7)
Cameron, Ed. A., 186 S. Burnett st., E. Orange (7)
Campbell, Duncan, Woodbury (8)
Campbell, H. B., 21 Court st., Newark (7)
*Campbell, Wellington, Short Hills (7)
Campbell, Wm., 144 Harrison st., E. Orange (7)
Campbell, Wm. K., Long Branch (13)
*Campus, Ellis, 612 W. Front st., Plainfield (20)
Cannon, E. A., 5360 Hudson Blvd., N. Bergen (9)
Cantini, Raphael, 934 Plainfield av., Plainfield (20)
Cantrell, W. C., 88 Union st., Clifton (16)
Capuano, Giacinto, 829 S. 4th st., Camden (4)
Carberry, Edward T., Wharton (14)
Carbone, Francis R., 157 Hunterdon st., Newark (7)
Card, Charles F., 100 W. Milton av., Rahway (20)
Cardinale, Pasquale, 542 Eliz. av., Elizabeth (20)
Cardwell, E. P., 15 Fulton st., Newark (7)
Carlander, O. R., 1972 Browning rd., M'ch'tville (4)
Carlisle, John H., 129 Prospect st., Passaic (16)
Carlon, Edward J., 20 Jaques av., Rahway (20)
Carlough, D. J., 426 Edison st., Paterson (16)
Carman, F. F., 31 Lincoln Park, Newark (7)
Carmen, J. H., 602 Crescent av., Plainfield (20)
Carmona, Lewis R., Tuckerton (15)
Carpenter, Wm. H., Woodbury (8)
Carr, Mary B., 1 Astor pl., Jersey City (9)
Carrington, Wm. J., 905 Pac. av., Atlantic City (1)
Carroll, C. Walter, 117 Center st., Trenton (11)
Carroll, Edgar, Main st., Dayton (12)
Caruso, Rocco J., 222 Mt. Prospect av., Newark (7)
Casale, John B., 496 Highland av., Newark (7)
Casilli, A. R., 618 Newark av., Elizabeth (20)
Casselman, A. J., 301 N. Second st., Camden (4)
Cassidy, John M., 1913 Blvd., Jersey City (9)
Cater, Doug. A., 55 Harrison st., East Orange (7)
Caverly, Fred S., 21 Grove st., Passaic (16)
Cerone, Daniel M., 89 Mt. Prospect av., Newark (7)
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth (20)
Chamberlain, A. R., 30 Lenox pl., Maplewood (7)
Chamberlain, John L., Sergeantville (10)
Chapman, E. J., 203 Danforth av., Jersey City (9)
Chapman, O. P., 270 Morris av., Eliabeth (20)
Chapman, R. W., 835 Bergen st., Newark (7)
Chapnick, M. M., 117 Paterson st., Paterson (16)
Charlton, C. C., 124 S. Illinois av., Atlantic City (1)
Chase, W. E., 587 Main st., Passaic (16)
Chattin, J. F., 671 Broad st., Newark (7)
Chayes, Sidney, 980 Ave. C, Bayonne (9)
Cherashore, H., 363 Centre st., Nutley (7)
Chester, Saul W., 264 Graham av., Paterson (16)
Chew, Elisha C., 603 Pacific av., Atlantic City (1)
Chianese, C. Chester, 464 Hamilton av., Trent'n (11)
Chiger, Alex. S., 621 High st., Newark (7)
Child, F. M., 1222 Bloomfield st., Hoboken (9)
Child, Florence C., 317 City Hall, Trenton (11)
Childers, Robt. J., 604 Park av., Plainfield (20)
Chmelnik, A. G., 299 Clinton av., Newark (7)
Christian, Henry A., 111 Fairview av., Jer. City (9)
Christian, Thomas B., Greystone Park (14)
Christensen, A. H., Lebanon (10)
Ciliberti, Frank J., 5th & Pine sts., Camden (4)
Clark, Charles C., 461 N. Y. av., Union City (9)
Clark, Ernest B., 209 Haddon av., Westmont (4)
Clark, Frank G., White House Station (10)
Clark, John H., 108 Orange rd., Montclair (7)
Clark, S. W., 152 S. No. Carolina av., Atl. City (1)
Clarke, Edward W., West Englewood (2)
Clarke, F. W., 47 Bayard st., N. Brunswick (12)
Clarken, Jos. A., 43 Lincoln Park, Newark (7)
Clay, Thos. A., 351 Totowa av., Paterson (16)
Clayton, John C., Freehold (13)
Clement, Levina B., 124 Kings hwy., W.H'dd'nf'd(4)

Clippinger, R. D., Vineland (6)
Closson, Edward W., Lambertville (10)
Cloud, A. W., Englewood (2)
Cobham, Jas. L., 78 Brinkerhoff st., Jersey City (9)
Coble, Morris S., 102 Washingt'n st., P. Amboy (12)
Coburn, John W., 25 S. Munn av., E. Orange (7)
Cochrane, Cleland D., Closter (2)
Coe, Richard, 156 Clinton av., Newark (7)
Coen, Lawrence E., 88 Washington av., Clifton (16)
Coffin, Henry, 433 Mt. Prospect av., Newark (7)
Cogan, Henry, 128 Carroll st., Paterson (16)
Coghlan, Jasper, 17 Academy st., Newark (7)
Cohen, C. C., 217 W. Hanover st., Trenton (11)
Cohen, Harry F., 660 Jersey av., Jersey City (9)
Cohen, Herman, 489 Jersey av., Jersey City (9)
Cohen, Herman, 1419 Hamilton av., Trenton (11)
Cohen, Herman N., 714 Park av., Hoboken (9)
Cohen, M., 106 Valley rd., Montclair (7)
Cohen, Meyer J., 32 Runyon st., Newark (7)
Cohen, N. B., 232 State st., Perth Amboy (12)
Cohen, Samuel A., 112 Mercer st., Jersey City (9)
Cohen, Sidney L., 20 Avon av., Newark (7)
Cohn, Herman, 393 Clinton av., Newark (7)
Cohn, G. M., 748 S. 10th st., Newark (2)
Cohn, Royal M., 740 Clinton av., Newark (7)
Cole, Blase, Newton (19)
Cole, L. Frank, 242 Broadway, Paterson (16)
Cole, Walter H., 537 Westfield av., Elizabeth (20)
Coleman, A. H., Clinton (10)
Coleman, Joseph G., Hamburg (19)
Collier, Martin H., Camden Co. Hosp., Lakel'd (4)
Collier, Wm. S., 1000 S. Broad st., Trenton (11)
Collins, H. J., 1160 Hamilton av., Trenton (11)
Collins, Jas. J., Main st., Woodbridge (12)
Collins, Lawrence M., Greystone Park (14)
Colmer, Meyer J., 407 Lyons av., Newark (7)
Colsh, LeRoy, 612 Ridgewood rd., Maplewood (7)
Comando, Harry N., 31 Lincoln Park, Newark (7)
Comeau, George, Greystone Park (14)
Comfort, John B., 50 S. Clinton av., Trenton (11)
Communale, A. R., 63 Irving st., Rahway (20)
Comora, Herman C., 317 16th st., W. New York (9)
Conaway, Walt P., 1723 Pac. av., Atlantic City (1)
Condon, John F., 686 Mt. Prospect av., Newark (7)
Condon, Wm. J., 50 Livingston av., N. Bruns. (12)
*Cone, Ralph, Westwood (2)
Conlon, Philip, 25 James st., Newark (7)
Connamacher, H. S., 671 Springfield av., Newark (7)
Connell, Emmet J., 2227 Blvd., Jersey City (9)
Connell, John, 977 Summit av., Jersey City (9)
Connell, John N., 26 Carleton av., Jersey City (9)
Connelly, J. A., 212 W. State st., Trenton (11)
Connolly, John J., 212 Market st., Newark (7)
Connolly, Richard N., City Hospital, Newark (7)
Connolly, Thos. W., 921 Bergen av., Jer. City (9)
Connor, Clarence A., Fort Lee (2)
Conoly, Lacy N., 601 Walnut st., Camden (4)
Conroy, John S., Burlington (3)
Conty, Anthony J., 318 48th st., Union City (9)
Cook, H. F., 31 Lincoln Park, Newark (7)
Cooke, Wm. H., 303 Main st., East Orange (7)
Cooney, Chas. J., 121 S. Illinois av., Atl. City (1)
Cooper, Edward P., Hamden, N. Y. (14)
Cooper, H. M., Ridge rd. & Passaic av., Ruth. (2)
Cooper, I. J., 71 Livingston av., N. Brunswick (12)
Cooper, J. Howard, East Millstone (18)
Cooperman, Wm., 647 Market st., Newark (7)
Corbusier, H. D., 612 Park av., Plainfield (20)
Corio, George A., 309 Clinton av., Trenton (11)
Corn, David, Ridgefield Park (2)
Cornwell, Alfred W., Bridgeton (6)
Cornwell, F. W., 207 E. 7th st., Plainfield (20)
Corpening, Flave H., Park av., Laurel Springs (4)
Corrigan, Geo. F., 344 Lafayette st., Newark (7)
Corrigan, Patrick H., 1720 Broad st., Trenton (11)
Corson, Elton S., Bridgeton (6)
Corson, Allen, Ocean City (5)
Corson, Filbert R., 101 S. Indiana av., Atl. City (1)
Cortese, A. E., 119 Jasper st., Paterson (16)
Corwin, Theo. W., 671 Broad st., Newark (7)
Cosgrove, Samuel A., 254 Union st., Jersey City (9)
Costello, William Francis, Dover (14)
Costill, Henry B., 371 Hamilton av., Trenton (11)
Cotton, Henry A., State Hospital, Trenton (11)
Cottone, R. J., 683 Princeton av., Trenton (11)
Cottrell, J. G., 159 Market st., Perth Amboy (12)
Coughlan, Ella A., 10 Oakwood av., Orange (7)
Coughlin, Frank J., 594 Kearny av., Kearny (7)
Coultas, A. B., Madison (14)
Coward, Edwin H., 1423 Pacific av., Atl. City (1)
Cowlbeck, H. D., 224 W. State st., Trenton (11)
Cox, Harold G., Hightstown (11)
Cox, William W., 27 S. Fullerton av., Montclair (7)
Cox, John Calvin, 55 Woodland rd., Maplewood (4)
Coxson, Harold P., Laurel rd., Stratford (4)
Cracco, Fred A., 51 Palisade av., Union City (9)
Craig, Henry A., Somerville (18)
Crain, W. E., Mt. Ephraim (8)
Crandall, John Kenneth, Fort Lee (2)
Crane, Bernard, 306 Pacific av., Atlantic City (1)
Crane, Charles G., 78 Farley av., Newark (7)
Crane, J. Welling, State Prison, Trenton (11)
Crankshaw, C. W., Pru. Ins. Co., Newark (7)
Craster, Chas. V., 381 Parker st., Newark (7)
Crawford, Georgiana U., 28 Carnegie av., E. Or. (7)
Crawford, John W., Bedminster (18)
Crecca, Wm. D., 111 Park av., Newark (7)
Cregar, Peter B., 420 Grant av., Plainfield (20)
Cremens, John F., 144 Carroll st., Paterson (16)
Crist, W. A., 725 Collings av., W. Collingswood (4)
Cronin, Francis J., 730 South st., Elizabeth (20)
Cronk, E. Irving, 57 Liv'gst'n av., N. Brunsw'k (12)
Cropsey, Charles D., Rutherford (2)
Crossfield, H. C., 491 S. Orange av., S. Orange (7)
Crounse, D., 84 Broadway, Passaic (16)
Crowe, Aldrich C., Ocean City (5)
Crowley, Jos. W., 4005 Westville av., Camden (4)
Crowley, S. W. F., 148 Belmont av., Jersey City (9)
Cryder, Millard, Cape May Court House (5)
Crystell, E. H., Hillside av., Nutley (7)
Csema, E. J., 151 Somerset st., N. Brunswick (12)
Culver, Geo. M., 27 Glenwood av., Jersey City (9)
Culver, S. Herbert, 75 Magnolia av., Jersey City (9)
Cummins, G. Wycoff, Belvidere (21)
Cunningham, Charles, Jr., Vineland (6)
Currie, N. W., 508 Central av., Plainfield (20)
Curry, Marcus A., Greystone Park (14)
Curtis, Austin M., 445 Van Houten st., Paterson (16)
Curtis, Donald, Hackensack (2)
Curtis, Elbert A., Central av., Newark (7)
Curtis, Frank W., Stewartville (21)
Curtis, Grant P., 312 36th st., Union City (9)
Curtis, Howard C., Moorestown (3)
Cuskaden, A. D., 5902 Ventnor av., Ventnor City (1)

Associate Members

Cohen, I. E., 67 Hunterdon st., Newark (7)
Cohen, William, 1007 Greenwood av., Trenton (11)
Carroll, Wm. V., 211 Academy st., Trenton (11)

D'Aclerno, P. A., 346 Palisade av., Union City (9)
D'Agostin, Henry, Cliffside (2)
D'Arcy, Walt. E., 545 E. State st., Trenton (11)
Dalton, S. Eugene, 1616 Pacific av., Atl. City (1)
Daly, Bert J., 151 Ave. C, Bayonne (9)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Dandois, George F., Wildwood (5)
Dane, Charles, 61 Scotland rd., South Orange (7)
Dane, John, 61 Scotland rd., South Orange (7)
Danzis, Max, 31 Lincoln Park, Newark (7)
Darby, A. Eugene, Ocean City (5)
Darden, Walter T., 149 W. Kinney st., Newark (7)
Darlington, Emlen P., New Lisbon (3)
Darnall, Wm. Edg., 5 So. Morris av., Atl. City (1)

Daron, Simeon, 405 Westminster av., Elizabeth (20)
Davenport, I. P., 270 Washington ter., Adubon (4)
*Davenport, Geo. S., 61 Passaic av., Passaic (16)
Davenport, Peter B., 764 S. Or. av., Newark (7)
Davey, Thomas N., 41 W. 33rd st., Bayonne (9)
Davidson, E. Norwell, 102 Elm st., Linden (20)
Davidson, Harold S., 1616 Pacific av., Atl. City (1)
Davidson, Henry A., 31 Lincoln Park, Newark (7)
Davies, George A., Elmer (6)
Davis, Albert B., 511 Cooper st., Camden (4)
Davis, E. Vernon, Vincentown (3)
Davis, F. C., 129 Summit av., Summit (20)
Davis, Harold L., 178 W. State st., Trenton (11)
Davis, J. Stannard, Haddonfield (4)
Davis, Jacob M., Burlington (3)
Davis, Richard M. A., Salem (17)
Davis, Stanton H., 420 Park av., Plainfield (20)
Davis, Wm. Cole, 124 S. Illinois av., Atl. City (1)
Davison, Royden W., 201 W. State st., Trenton (11)
Dawson, Harry, 618 E. 24th st., Paterson (16)
Day, Grafton E., Frazier & N. J. avs., Coll'gsw'd (4)
Day, Samuel Thomas, Port Norris (6)
Day, Willis B., 154 E. 7th st., Plainfield (20)
Dayton, S. T., Englewood (2)
De Cesare, F. D., 500 Walnut st., Roselle (20)
Decker, Chas. T., 510 Prospect av., Westfield (20)
Decker, Clinton L., 40 S. Kingman rd., S. Or. (9)
Decker, F. H., Frenchtown (10)
Decker, J. G., Hasbrouck Heights (2)
De Freitas, Clement, 115 W. 4th st., Plainfield (20)
DeFronzo, Morando, 180 Fairmount av., New'k (7)
DeFuccia, C. P., 47 Glenwood av., Jersey City (9)
*DeGroot, George S. Mendham (14)
de Hellebranth, Roland T., 104 S. F'kf'd av., V'tnor (1)
Deibert, Irwin E., 618 Benson av., Camden (4)
Deichman, Charles H., Morristown (14)
Delario, A. J., 56 Cross st., Paterson (16)
Del Deo, Nicholas, 47½ State st., Newark (7)
Del Duca, Vincent, 406 Cooper st., Camden (4)
DelGuercio, O., 342 Clifton av., Newark (7)
Demarest, L. M., 228 S. Orange av., S. Orange (7)
De Mattia, Michael, 71 —Cedar st., Paterson (16)
DeMeritt, Chas. L., 415 32nd st., Hoboken (9)
De Michele, Roland V., 456 Roseville av., New'k (7)
Denelsbeck, J. O., 878 E. State st., Trenton (11)
Denes, O. J., 402 Central av., Nutley (7)
Dengler, H. P., Morris av., Springfield (20)
Dennin, Joseph W., 308 Chestnut st., Roselle (20)
Dennis, Louis A., 42 McLaren st., Red Bank (9)
Denniston, Frank, Point Pleasant (15)
Denton, P. P., 951 Madison av., Paterson (16)
DePons, S. C., 501 Grand av., Red Bank (13)
Deriveaux, John A., 103 Clinton av., Newark (7)
De Rosa, Armond, 150 Fair st., Paterson (16)
De Rosa, John, 150 Fair st., Paterson (16)
DeVausney, Winif'd S., 50 James st., Newark (7)
DeVincentis, Henry, 285 Henry st., Orange (7)
Devlin, Frank, 617 Broadway, Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
Dexter, Harriet E. T., 903 Ave. C, Bayonne (9)
DeYoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Chas. N., Jr., Englewood (2)
Dias, Joseph L., 17 Lombardy st., Newark (7)
Dickson, J. D., Bogota (2)
Dieker, Howard, 78 Main st., South River (12)
Dieffenback, R. H., 570 Mt. Prospect av., New'k (7)
Dilger, Fred'k G., Cliffside (9)
Dillingham, W. I., 431 15th st., W New York (9)
Dinge, Ferdinand Chas., 31 Lincoln P'k, Nwk. (7)
Dingman, N. M., 351 Van Houten st., Paterson (16)
*Dingman, Thos. A., 330 Broadway, Paterson (16)
Disbrow, G. Ward, 126 Mountain av., Summit (20)
Disbrow, Harold B., Lakewood (15)
Disbrow, Vanderhoof M., Lakewood (15)
Diverty, Henry B., Woodbury (8)
Dodd, Edw. L., 157 Forest st., Belleville (7)
Dodd, Raymond C., 16 Snowden pl., Glen Ridge (7)
Dodd, William E., Beach Haven (15)
Dodson, Louis, 592 Jersey av., Jersey City (9)
Doer, Harry, Electric Bldg., Asbury Park (13)
Doherty, Wm. John, 201 N. Main st., Pl'tville (1)
Dolganos, Moses, 268 Palisade av., Jersey City (20)
Donahue, Wm. J., 173 Roseville av., Newark (7)
Donchi, S. M., 346 Belmont av., Newark (7)
Donnelly, Robt. J., 208 W. Market st., Newark (7)
Donoho, Al. P., Walnut & Center, M'chantville (4)
Donohoe, Lucius F., 140 West 8th st., Bayonne (9)
Donovan, Joseph, Morris Plains (14)
Donovan, William, Brielle (13)
Doody, Wm. M., 19 Bentley av., Jersey City (9)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 921 Bergen av., Jersey City (9)
Doremus, Widmer E., 31 Lincoln Park, Newark (7)
Dorn, Elliot I., 267 Vassar av., Newark (7)
Dougherty, Daniel D., 206 10th st., Hoboken (9)
Douress, P. C., 802 E. State st., Trenton (11)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Downs, Roscius I., Riverside (3)
Downs, Elwood E., Woodbury (8)
Draesel, Chas., 509 22nd st., Union City (9)
Draggett, E. Hugh, 441 W. Front st., Plainf'd (20)
Dragonetti, E. N., 177 Clifton av., Newark (7)
Drake, Daniel E., Gr'nw'd Lake rd., N'wf'ndl'nd (16)
Drake, L. B., Ogdensburg (19)
Dreskin, J. L., 172 Lyons av., Newark (7)
Driscoll, Chas. D., 213 Clements Br.rd., Barringt'n (4)
Drury, Alfred J., 150 2nd av., E. Roselle Park (20)
Dubell, John E., Columbus (3)
Dublin, Geo. T., 211 N. 5th st., Camden (4)
DuBois, M. G., 769 High st., Newark (7)
duBusc, L. C. Victor, 399 Westfi'd av., Eliz'b'th (20)
Duckett, Warren J., 21 Carlton av., Jersey City (9)
Dukes, Howard R., 220 Kearny av., Kearny (9)
Dulin, Everett K., 144 Harrison av., E. Orange (7)
*Duncker, Frederick W., 136 Monmouth st., Nk. (7)
Dundon, A. H., N. Plainfield (18)
Dunlap, Thos. G., 47 So. Virginia av., Atl. City (1)
Dunn, John S., Salem (17)
Dunning, Walt L., 606 E. 26th st., Paterson (16)
Durant, H. J., 526 B'way, Paterson (16)
Durrah, F. F., 310 Plainfield av., Plainfield (20)
Dwyer, Wm. A., 99 Park av., Paterson (16)

Associate Members

Davis, Louis, 825 S. 10th st., Newark (7)
Deignan, Wm. L., 257 Dodd st., E. Orange (7)
Deutel, O. R., 283 Franklin st., Bloomfield (7)
D'Gianni, Nichalos H., Columbus (11)
Dimun, John T., 960 S. Broad st., Trenton (11)
Doranz, Harold K., 38 S. Hermitage av., Tr'nt'n (11)
Dranow, Paul, 205 Franklin av., Nutley (7)
Driscoll, Raymond S., 919 Blvd., Bayonne (9)
Dunn, Theodore, 326 Park st., Hackensack (2)

Eagleton, Wells P., 15 Lombardy st., Newark (7)
Eason, S. W., 48 DeForrest av., Summit (20)
*Eaton, Alvin R., 116 W. Jersey st., Eliabeth (20)
Eaton, Arthur T., 201 4th av., Haddon Heights (4)
Ebenfield, S. W., 344 High st., Newark (7)
Echikson, Jos. I., 845 S. 12th st., Newark (7)
Ecker, Joseph, 197 Hancock av., Jersey City (9)
Eckert, William, 672 Palisade av., Union City (9)
Eckhardt, Ralph A., Madison (14)
Edelen, James J., 280 S. Clinton st., E. Orange (7)
Edelson, Samuel, 1141 Corlies av., Neptune (13)
Edgar, Joseph A., 71 Congress st., Jersey City (9)
*Edwards, G.L., c/o P.S.Clarke, 255 Ry'rs'n st., B'kl'n (2)
Edwards, James B., Leonia (2)
Edwards, Lena, 258 Pacific av., Jersey City (9)
Eigen, Louis A., 190 Clinton av., Newark (7)
Ein, William B., 31 Lincoln Park, Newark (7)
Elias, Elmer, 533 S. Broad st., Trenton (11)
Ellis, Alexander, 513 Broadway, Camden (4)
Elmer, Matthew K., Bridgeton (6)

Elsasser, Theo., 906 Park av., Woodcliff (9)
Elwell, Alfred M., 407 Cooper st., Camden (4)
Ely, Lancelot, Somerville (18)
Emerson. Linn, 310 Main st., Orange (7)
Emmer, S. Wolfe, 234 Clinton av., Newark (7)
Emory, G. B., 1 Franklin pl., Morristown (7)
English, James R., 51 Cypress st., Newark (7)
English, Samuel B., Glen Gardner (10)
Enright, J. G., 25 Kensington av., Jersey City (9)
Epler, Don A., 45 Hillside av., Newark (7)
Epstein, Harry H., 225 Perry st., Trenton (11)
Epstein, Henry B., 31 Lincoln Park, Newark (7)
Erler, Eugene W., 119 No. 5th st., Newark (7)
Ernest, R. B., 240 W. State st., Trenton (11)
Erwin, Millard, 572 Prospect st., Maplewood (12)
Essertier, Edward P., Hackensack (2)
Ethridge, Chas. E., 376 Prospect st., E. Orange (7)
Evans, Charles H., 144 Harrison st., E. Orange (7)
Evans, David P., 144 Harrison st., E. Orange (7)
Evans, Jas. L., 893 Park av., N. Bergen (9)
Evans, Winborne D., 2704 W'sville av., Camden (4)
Ewens, Arthur E., 3600 Pac. av., Atlantic City (1)
Ewing, Harvey M., 31 Lincoln Park, Newark (7)
Ewing, Leslie H., Broad st., Berlin (4)

Facciolo, Frank, 562 Boulevard, Bayonne (9)
Fagan, Jas. L., 419 George st., N. Brunswick (12)
Fager, Rudolph O., 96 Broad st., Bloomfield (7)
Fahrenbruch, F. D., Mt. Holly (3)
Failing, Brayton E., 31 Lincoln Park, Newark (7)
Fairbanks, Warren H., Freehold (13)
Faison, John B., 45 Glenwood av., Jersey City (9)
Falcone, C., 197 Sanford av., N. Brunswick (12)
Falvello, W. A., 28 Westmore av., Morristown (14)
Fanberg, Sol. J., 31 Lincoln Park, Newark (7)
Fanelli, Antonio, 469 Lowrie st., P. Amboy (12)
Farden, Joseph L., 342 Roseville av., Newark (7)
Farmer, Vincent, Hackensack (2)
Farmer, W. D., Allentown (11)
Farr, Irving L., 214 Walnut st., Montclair (7)
Farr, J. C., 75 10th st., Hoboken (9)
Farr, W. J., Teaneck (2)
Farrell, Edgar A., 100 King's H'w'y, W.H'd'nf'ld(4)
Farrow, J. Willard, Dover (14)
Fasano, G., 194 S. 7th st., Newark (7)
Fattel, Henry C., 142 Chadwick av., Newark (7)
Faughnan, Rose, 97 High st., Passaic (7)
Faulkingham, R. J., 61 Livingston, N. Bruns. (12)
Featherston, Dan'l F., 506 4th av., Asbury Park(13)
Fechner, Julius, 138 W. Kinney st., Newark (7)
Federman, P. H., 220 Fairmount av., Newark (7)
Fee, Elam K., Lawrenceville (11)
Feher, L. A. M., 196 Somerset st., N. Brunsw'k (12)
Feigenoff, I., 420 Broadway, Paterson (16)
Feinberg, Harry D., 384 2nd av., Long Branch (13)
Feit, Herman, 7 Kensington av., Jersey City (9)
Fell, Alton S., 529 E. State st., Trenton (11)
Fellman, M., 118 Jewett av., Jersey City (9)
Fendrick, Edward, 138 Park pl., Irvington (7)
Fenton, Tennet E., Manasquan (13)
Ferenczi, Louis J., 33 Edwards st., Bayonne (9)
Ferguson, Chas., 435 Westminster av., Eliz'b'th (20)
Ferguson, W. E., Nwk. Conv'l'nt Hosp., M'pl'w'd(7)
Fern, S. S., 122 Elizabeth av., Newark (7)
Ferris, Ruth, 12 De Hart st., Morristown (14)
Fewsmith, Joseph L., 120 Second av., Newark (7)
Field, Frank L., Far Hills (18)
Fielding, William M., Allendale (2)
Fiering, A. M., Pompton Turnpike, M'nt'n View(16)
Filkins, Cedric E., 418 W. Horse Pike, Audubon (4)
Fine, H. P., 185 Market st., Perth Amboy (12)
Fine, Moses J., 175 Clinton av., Newark (7)
Fineburg, Bernard J., 674 Bergen av., Jersey C'y(9)
Fineberg, Jacob, 116 Bergen av., Jersey City (9)
Finegan, P. J., 752 Greenwood av., Trenton (11)
Finesilver, Ed. M., 31 Lincoln Park, Newark (7)
Fink, Irving E., 129 Lyons av., Newark (7)
Finke, Charles H., 317 York st., Jersey City (9)
Finke, George W., Hackensack (2)
Finke, John H. D., Hackensack (2)
Finkel, Joshua, 368 Clinton av., Newark (7)
Finkelstein, A. S., 174 Johnson av., Newark (7)
Finkler, Rita S., 99 Lyons av., Newark (7)
Finn, Frederick A., 921 Bergen av., Jersey City (9)
Fischer, E. J., 29 Ashwood ter., W. Orange (7)
Fischer, John S., 20 S. Jackson av., Ventnor (1)
Fischman, H. H., 34 Sterling st., Newark (7)
Fish, Clyde M., Washington av., Pleasantville (1)
Fisher, James A., 501 Grand av., Asbury Park (13)
Fisher, Samuel, Madison av., Paterson (16)
Fisher, Stella C., 4401 Westfield av., Camden (4)
Fishkoff, A., 360 State st., Perth Amboy (12)
Fithian, George W., 266 High st., Perth Amboy (12)
Fitch, Thomas, 744 Watchung av., Plainfield (20)
Fitzhugh, W. F., Ridgefield Park (2)
Fitzpatrick, Ed. F., 574 Warren st., Newark (7)
Flaherty, M. E., 36 Glenwood av., Jersey City (9)
Fleming, C. L., Pennsgrove (17)
Fleeter, Meyer A., 893 Magie av., Elizabeth (20)
Flichtenfeld, Morris, 283 4th st., Jersey City (9)
Fliegel, William, Maywood (2)
Flint, Edgar, Raritan (18)
Flitcroft, William, 510 River st., Paterson (16)
Flower, M. A., 39 Lincoln Park, Newark (7)
Flynn, E. A., 161 Washington av., Belleville (7)
Flynn, Thomas H., Somerville (18)
Fooder, H. M., Williamstown (8)
Fordyce, C. P., P. O. Box 322, Westfield (20)
Forman, Howard S., 640 Bergen av., Jer. City (9)
Forney, Norman N., Main st., Milltown (12)
Forsyth, Kenneth C., 530 Summer av., Newark (7)
Fort, J. Irving, 306 Roseville av., Newark (7)
Forte, Frank S., 456 Roseville av., Newark (7)
Foster, Frank L., 320 Springfield, W. Cranford (20)
Foster, Herbert W., 2 Erwin Park, Montclair (7)
Foster, W. S., 233 Mt. Prospect av., Newark (7)
Fowler, Royal H., 744 Broad st., Newark (7)
Fox, James W., Hillsdale (2)
Fox, S. W., 513 Raritan av., New Brunswick (12)
Fox, William W., 101 S. Indiana av., Atl. City (1)
Francis, Adaline M., Somerville (18)
Frank, Morris, 920 Ave. C, Bayonne (9)
Frank, Myrtle G., 227 Phila. st., Egg Harbor (1)
Franklin, C. C., 1012 Hamilton av., Trenton (11)
Franklin, I. H., 191 Palisade av., Jersey City (9)
Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
Franklin, Louis, 191 Palisade av., Jersey City (9)
Franklin, S. I., Englewood (2)
Frederick, Gus H., 349 Camden st., Newark (7)
Freeland, Frank, Hackensack (2)
Freeman, Geo. C., 1 Lenox pl., Maplewood (7)
Freeman, R'h'd D., 103 Scotland rd., S. Orange (7)
Freile, William, 25 Tonnele av., Jersey City (9)
Freinkel, J., 2 Hillside av., Newark (7)
Freidburg, Geo. H., 1139 E. Broad st., Elizabeth (20)
Friedman, H. H., Freehold (13)
Friedman, Milton, Nwk Beth Israel Hosp., Nwk.(7)
Friedman, M. H., 526 N. Clinton av., Trenton (11)
Friedmann, L. L., 484 Princeton av., Trenton (11)
*Fritts, Herbert Harold, Shiloh (6)
Froelich, J. C., 74 Ingraham pl., Newark (7)
Frohwein, Ida H., 119 Morrist'n rd., Elizabeth (20)
Frost, Inglis F., 26 Maple av., Morristown (14)
Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
Fuhrmann, Barclay Stokes, Flemington (10)
Fulper, Theodore B., Hampton (10)
Funk, Joseph, 615 Elizabeth av., Elizabeth (20)
Funkhouser, Ed. B., State Hospital, Trenton (11)
Furlonge, H. Rowland., 432 Jackson av., Jer. C'y (9)
Furman, Benj. A., 31 Roseville av., Newark (7)
Furman, Sol. T., 88 Kensington av., Jersey City (9)
Furst, Nathan J., 190 Johnson av., Newark (7)

ASSOCIATE MEMBERS

Feinberg, Harry, 11 W. 23rd st., Bayonne (9)
Fialk, Harry, 541 44th st., Union City (9)
Forer, Robert, 247 Centre st., Trenton (11)
Frank, Nathan, 186 Bowers st., Jersey City (9)
Freiman, Hyman, 744 Ave C, Bayonne (9)
Friedman, Abraham I., 145 M'rsh'll av.,Little F'ry(2)
Friedman, Harry, 721 S. 16th St., Newark (7)

Gairdner, T. M., Gibbstown (8)
Galasso, Attilio, 275 Speedwell av., Morristown (14)
Galloway, Geo. E., 109 Milton av., Rahway (20)
Gamon, Robert S., 558 Newton av., Camden (4)
Gandy, Charles M., Ocean View (5)
Ganley, Arthur J., 390 Park av., East Orange (7)
Ganot, F. I., 639 Ridge st., Newark (7)
Gantz, O. E., 215 N. Grove st., E. Orange (7)
Gardam, J. W., 16 Longfellow av., Newark (7)
Gardner, John W., 436 Ocean av., Jersey City (9)
Garrabrant, Clarence, 19 N. Penn., Atlantic City (1)
Garrett, Harry S., Park Ridge (2)
Garrison, Walter Sherman, Cedarville (6)
Gauch, William, 177 Elwood av., Newark (7)
Gauzza, Valentine P., Fords, N. J. (12)
Geary, Daniel J., Morristown (14)
Geary, Russell D., Riverside (3)
Geary, Paul, 706 Park av., Plainfield (20)
Gelber, Isaac, 30 Morris av., Union (20)
Gelber, L. J., 41 Lincoln Park, Newark (7)
George, M. E. W., 805 Broadway, Newark (7)
Gerendasy, J., 225 E. Jersey st., Elizabeth (20)
German, George B., 429 Cooper st., Camden (4)
Gerne, Timothy, 972 Summit av., Jersey City (9)
Gersham, J. G., Dumont (2)
Gershenfeld, David B., 20 Hillside av., Newark (7)
Gesswein, C. A., Keyport (13)
Ghee, Euclid, 115 Clairmont av., Jersey City (9)
Giambra, S. M., 666 Broadway, Paterson (16)
Gibb, W. Blake, Madison (14)
Gibbs, Alice S., 339 Union av., Elizabeth (20)
Gibbs, Jonathan C., 34 Spring st., Trenton (11)
Gifford, W. Royal, 247 Park av., East Orange (7)
Giglio, A. S. V., 626 Elizabeth av., Elizabeth (20)
Gilady, Ralph. Hackensack (2)
*Gilbert, H. J., 588 Broadway, Newark (7)
Gilbertson, R. L., Madison (14)
Gille, Hugo, 149 Congress st., Jersey City (9)
Gillett, H. E., Ramsey (2)
Gillson, H. V., 21 Lee pl., Paterson (16)
Gillson, John T., 170 Broadway, Paterson (16)
Gilman, Malcolm B., 59 Seeley av., Arlington (7)
Gilpin, Freind B., Cranford (20)
Ginsberg, Geo., 624 Bloomfield st., Hoboken (9)
Ginsberg, Samuel, 136 Broadway, Passaic (16)
Gittelman, Morton, 1028 E. Jer. st., Elizabeth (20)
Glaser, E., 218 Marshall st., Elizabeth (20)
Glasgow, Thos., 120 Passaic av., Passaic (16)
Glass, Benj. E., 609 Watchung av., Plainfield (20)
Glass, Oscar, 638 High st., Newark (7)
Glass, William H., 144 Harrison st., E. Orange (7)
Glasston, H. M., 628 N. Wood av., Linden (20)
Glazebrook, F. H., 6 Altmont ct., Morristown (14)
Gleeson, Wm. John, 37 Monticello av., Jer. City (9)
Glover, Lawrence L., 232 King's Hwy.,Haddonf'd(4)
Gnasso, E. R., Fort Lee (2)
Godfrey, Allan O., 220 Roseville av., Newark (7)
Godlin, David R., 5580 Hudson Blvd., N. Bergen (9)
Goeller, J. D., 1165 W. Clinton av., Irvington (7)
Goffman, Emanuel, 81 Valley rd., Montclair (7)
Goldberg, Benj. M., 1156 E. State st., Trenton (11)
Goldberg, David, Westwood (2)
*Goldberg, E. H., 238 Kearny av., Kearny (9)
Goldberg, Louis E., 31 Lincoln Park, Newark (7)
Goldberg, L., 303 N. Washington av., Dunellen (12)
Goldberg, S. M., 353 Washington av., Belleville (7)
Goldfield, Harold H., 225 E. Jer. st., Elizabeth (20)
Golding, Harry N., 180 Carroll st., Paterson (16)
Goldmacher, H. B., 555 S. Broad st., Elizabeth (20)
Goldstein, A., Lakewood (15)
Goldstein, Henry Z., 190 Clinton av., Newark (7)
Goldstein, Hyman I., 1425 Broadway, Camden (4)
Goldstein, Samuel M., 40 Johnson av., Newark (7)
Goldstein, W. H., 632 Belgrove dr., Arlington (7)
Goldstein, H. H., 1065 E. Jersey st., Elizabeth (20)
Goodfellow, G. P., 161 Prospect st., E. Orange (7)
Goodrich, S. L., Std. Oil Co. of N. J., Jer. City (20)
Goodwin, William M., 75 Congress st., Newark (7)
Gordon, A., 616 Main av., Passaic (16)
Gordon, A. J., 273 Roseville av., Newark (7)
Gordon, Clark H., 808 E. State st., Trenton (11)
Gordon, Carl, 222 Caspian av., Atlantic City (1)
Gordon, Charles D., Mt. Arlington (14)
Gordon, Clifford M., 52 Main st., Paterson (16)
Gordon, I. L., 1815 Boulevard, Jersey City (9)
Gordon, J. B., Holmdel (13)
Gordon, Osher, 99 Prospect st., Passaic (16)
Gordon, William, Blairstown (21)
Gorezyea, A. G., 538 S. Broad st., Elizabeth (20)
Gosling, W. W., 23 Monmouth av., Red Bank (13)
Goudy, Elmer S., 187 Kearny av., Kearny (9)
Gould, J. H., 696 Ave. C, Bayonne (9)
Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
Graham, E. E., P. O. Box 195, Yardsville (11)
Graham, R. H., Paterson (16)
Gramsch, Louis, Glen Gardner (10)
Granelli, H. A., 213 Garden st., Hoboken (9)
Grant, William F., 162 Roseville av., Newark (7)
Gray, Charles M., Vineland (6)
Gray, John W., 142 Clinton av., Newark (7)
Gray, W. B., North Plainfield (18)
Gregorius, Ralph F., 120 Irvington av., S. Or. (7)
Gregory, Marie F., Green Village rd., Madison (14)
Gregory, Mildred G., 21 Roseville av., Newark (7)
Gregory, R. A., 121 E. 7th st., Plainfield (20)
Green, David W., Salem (17)
Green, James S., 463 N. Broad st., Elizabeth (20)
Green, M., 746 Palisade av., Weehawken (9)
Green, William H., 230 Bank st., Newark (7)
Greenberg, Philip, 1902 Hudson Blvd., Jer. City (9)
Greenberg, Samuel, 46 Johnson av., Newark (7)
Greene, A. D., 195 Palisade av., Union City (9)
Greenfield, A. W., Hackensack (2)
Greenfield, Bernard H., 691 Clinton av., Newark (7)
Greenfield, W. J., Hackensack (2)
Greengrass, Jacob L., 146 B'way, Paterson (16)
Greifinger, Marcus H., 22 Vassar av., Newark (7)
Greissinger, Karl, 422 20th st., W. New York (9)
Grier, Robert M., 50 E. Wash'gt'n av., Pl's'ntv'le(1)
Griesmier, Zadoc L., 1143 E. Jer. st., Elizabeth (20)
Grieve, James, 88 Market st., Perth Amboy (12)
Griffith, Roy, 909 Broad st., Newark (7)
Griffiths, Chauncey B., 31 Lincoln Park, Newark(7)
Grimes, Jessie R., Dumont (2)
Groff, P. A., Little Ferry (2)
Groves, Charles, State Hospital, Marlboro (13)
Gugliemelli, A. D., 449 Hamilton av., Trenton (11)
Guidi, Guido M., 212 Christine st., Elizabeth (20)
Guion, Edw., P. O. Box 418, Atlantic City (1)
Guillium, W. H., 505 Fourth av., Asbury Park (13)
Guthrie, W. G., 300 Summer av., Newark (7)
Gutkowski, W. T., 104 Grove ter., Irvington (7)
Gutmann, Benj., 51 Livingston av., N. Bruns. (12)
Gutowski, Jos. M., 433 Brace av., Perth Amboy(12)

ASSOCIATE MEMBERS

Gallo, James F., 32 Zabriskie st., Haledon (16)
Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)
Ghee, Peter F., 730 Ocean av., Jersey City (9)
Golden, Clement H., 81 Seymour av., Newark (7)

Hackett, Leon W., Washington (21)
Hadley, C. F., 201 W. Maple av., Merchantville (4)
Hagen, Orville, 266 VanHouten st., Paterson (16)
Hagerty, John F., 212 W. Market st., Newark (7)
Haggerty, Daniel L., 227 N. Warren st., Tr'nt'n(11)
Haggerty, Francis F., 1015 Wash. av., Hoboken (9)

Hagney, Fred W., 669 Elizabeth av., Newark (7)
Hahn, Katherine B., 272 Thornden st., S. Orange(7)
Hahn, William, 272 Thornden st., S. Orange (7)
Haight, Harry P., Raritan av., N. Brunswiek (12)
Haines, Edgar J., Medford (3)
Haines, Emerson S., 501 Grand av., Asbury Pk. (13)
Haines, Mabel S., 600 White H'se Pike, Audubon (4)
Haines, Wm. H., 217 Lafayette av., Audubon (4)
Haldeman, Robert E., Mt. Holly (3)
Haley, Mark J., 8106 Ventnor av., Margate (1)
Hall, Perry O., 254 Union st., Jersey City (9)
Hall, W. W., 266 Van Houten st., Paterson (16)
Hallett, Frederick S., Hackensack (2)
Halligan, Earl J., 254 Montgomery st., Jer. City (9)
Halligan, H. J., 254 Montgomery st., Jer. City (9)
Hallock, W. J., Berkley Heights, Summit (20)
Halpirin, Harry, 8 Washburn pl., Caldwell (7)
Halpern, Sophia L., 271 Palisade av., Union City (9)
Halstead, Charles F., Somerville (18)
Hamill, Patrick J., 50 Journal Sq., Jersey City (9)
Hammer, Walter, 306 16th st., W. New York (9)
Hampton, Geo. B., Greystone Park (14)
Hanan, James T., 11 The Crescent, Montclair (7)
Haney, John J., 167 Cooper st., Trenton (11)
Hanrahan, J. M., 1144 E. Broad st., Elizabeth (20)
Harden, Albert S., 540 Warren st., Newark (7)
Hardenberg, D. S., 347 Com'ip'w av., Jersey City (9)
Harhen, Geo. E., 22 Brookside av., Caldwell (7)
Harley, H. L., 101 S. Indiana av., Atlantie City (1)
Harman, Wm. J., 740 W. State st., Trenton (11)
Harmon, Byron M., Essex Co. San., Verona (10)
Harmon, Harry M., Frenchtown (10)
Harney, J. N., Teaneek (2)
Harquail, R. J., Greystone Park (14)
Harreys, Chas. W., 306 Broadway, Paterson (16)
Harris, Allen, Greenwieh (6)
Harris, Charles M., 501 Bergen av., Jersey City (9)
Harris, Morris, 82 Maple ave., Morristown (14)
Harrison, J. B., 302 E. Broad st., Westfield (20)
Harryman, Wm. K., Hackensack (2)
Hart, H. M., 300 Mt. Prospect av., Newark (7)
Harter, Louis F., 174 Bower st., Jersey City (9)
Hartman, Luther, Maple Shade (3)
Hartwell, H. A., 777 Boulevard, E. Weehawken (9)
Harvey, Edwin H., 20 N. Florida av., Atl. City (1)
Harvey, John W., 818 Ave. C, Bayonne (9)
Harvey, T. W., 59 Main st., Orange (7)
Harvey, Thos. W., Jr., 59 Main st., Orange (7)
Harrington, J. Henry, Rockaway (14)
Haseltine, S. L., 410 Westminster av., Elizabeth(20)
Hasking, A. P., 318 Montgomery st., Jersey City (9)
Hasney, Fred'k A., 292 Main st., W. Orange (7)
Hateh, Elvira D., Morristown (14)
Hauck, Lydia B., 644 Stuyvesant av., Irvington (7)
Hauek, Wm. H., 644 Stuyvesant av., Irvington (7)
Hausman, S. W., 50 W. Front st., Red Bank (13)
Haussling, Francis R., 661 High st., Newark (7)
Haven, Samuel C., 14 Elm st., Morristown (14)
Hawkes, E. Zeh, 84 Washington st., Newark (7)
Hawkes, Steuart Z., 84 Washington st., Newark (7)
*Hay, Joseph S., 255 High st., Perth Amboy (12)
Hayden, W. G., 41 Main st., Toms River (15)
Hays, Roy G., 567 Haddon av, Collingswood (4)
Haywood, Harry, 3 Elm Row, New Brunswiek (12)
Heath, Louanna, 20 Fairmount av., Newark (7)
Heatley, William, 23 Monmouth st., Red Bank (13)
Hegeman, Runkle F., Somerville (18)
Heil, A. Arling, Milford (10)
Heilbrunn, Julius, 135 Belmont av., Jersey City (9)
Heineken, T. S., 17 Park pl., Bloomfield (7)
Heinig, Frank G., Boonton (14)
Heintzelman, B. S., 19 W. 33d st., Bayonne (9)
Hekimian, J. H., 468 Palisade av., Weehawken (9)
Helff, J. R., Teaneck (2)
Heller, G. H., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)
Henion, Em'l L., 16 Chureh st., Paterson (16)
Henle, C. B., 671 Springfield av., Newark (7)
Henn, Louis D., N. Plainfield (18)
Henry, F. C., 254 State st., Perth Amboy (12)
Henry, F. C., Jr., 254 State st., Perth Amboy (12)
Henry, George, Flemington (10)
Herbener, E. G., Lakewood (15)
Herman, John H., 197 S. Centre st., Orange (7)
Hernandez, Manuel, 1974 Hudson Blvd., Jer. C'y (9)
Herndon, Louis S., 33 Johnson av., Newark (7)
Herrman, W. G., 501 Grand av., Asbury Park (13)
Herold, Harvey T., 850 S. 13th st., Newark (7)
Herradora, J. R., 50 Journal Sq., Jersey City (9)
Hessert, Edmund C., Hadden & Col. avs., C'll'w'd (4)
Hewson, James S., 163 Myrtle av., Millburn (7)
Hexamer, Fred, 50 Lyons av., Newark (7)
Heyman, Arthur, 79 Baldwin av., Newark (7)
Hicks, William H., 46 Milford av., Newark (7)
Hiden, J. C., 199 Nassau st., Prineeton (11)
Higgins, G. L., 94 Lembeck av., Jersey City (9)
*Higgins, Joseph F., 607 Center st., Trenton (11)
Higgins, Thos. A., 2616 Hudson Blvd., Jer. City (9)
Higgins, T. F., 146 Reid st., Elizabeth (20)
Hill, J. A., 511 Cedar av., Allenhurts (13)
Hill, Robert H., 332 Park av., Newark (7)
Hill, William F., 108 Grand st., Jersey City (9)
Hillegas, E. J., Mantua (8)
Hilker, George, 463 State st., Perth Amboy (13)
Hilliard, J., Manawawken (15)
Hilliard, William T., Salem (17)
Hilton, C. O., 598 N. 5th st., Newark (7)
Hinton, H. S., Parlin (12)
Hird, Emerson Freeman, Bound Brook (18)
Hirst, E. Reed, 586 Federal st., Camden (4)
Hirst, Levi B., 586 Federal st., Camden (4)
Hirsehfield, B. A., 1404 Glenwood av., Trenton (11)
Hitzeman, Louis A., 30 E. Passaic st., Maywood (2)
Hnat, Frederick, 450 Rahway av., Elizabeth (20)
Hoagland, Louis B., Oxford (21)
Hobart, Richard T., 191 Belleville av., U. Mont. (7)
Hoeler, Wm. F., 808 S. 11th st., Newark (7)
Hofer, Clarence J. M., Metuchen (12)
Hoffman, Chas. A., 24 Sl'py Hol'w lane, Pl'nf'ld(20)
Hoffman, Florentine M., 91 Bayard st., N. Bruns. (12)
Hoffman, Peter, 2672 Boulevard, Jersey City (9)
Hogan, Carlton P., Burlington (3)
Hoheb, A. S., Rutherford (2)
Hoheb, K. R., Rutherford (2)
Holden, Edgar, Jr., 217 Broadway, Newark (7)
Holland, John A., 194 W. State st., Trenton (11)
Holland, Geo. A., 364 Clinton av., Newark (7)
Holler, Henry G., 234 Montclair av., Newark (7)
Hollingshead, Lyman B., Pemberton (3)
Hollingshed, Beulah S., 600 Benson st., Camden (4)
Hollingsworth, H. H., 86 First st., Clifton (16)
Hollinshed, Ralph K., Westville (8)
*Holloway, J. Morgan, 633 Bergen av., Jer. C'y (9)
Holmes, F. J. E., 151 Fair st., Paterson (16)
Holmes, Grace A., 1077 E. Jer. av., Eliabeth (20)
Holmes, George J., 17 Elizabeth av., Newark (7)
Holt, Edw. Z., Children's Seaside Home, Atl. C'y (1)
Holt, Herman H., 258 Graham av., Paterson (16)
Holters, Otto R., 513 2d av., Asbury Park (13)
Hommell, P. E., 689 Bergen av., Jersey City (9)
Hoops, Harold J., 167 Ege av., Jersey City (9)
Hoover, A. R., 5 Prinee st., Elizabeth (20)
Horn, Max, 80 Lyons av., Newark (7)
Hornberger, J. Howard, Roebling (3)
Horner-Roger, Clara L., 721 Cooper st., Camden(4)
Hornstine, H. H., Wildwood (5)
Horowitz, H. J., Moresmere (2)
Horre, G. W. H., 204 W. Jersey st., Elizabeth (20)
Horsford, Fred C., 305 Broadway, Newark (7)
Hosp, Paul H., 842 S. 12th st., Newark (7)
Houek, Wm. J., 207 Mt. Prospeet av., Newark (7)
Howard, J. E., 67 Kings H'way W., Haddonfield (4)
Howell, E. G., New st., New Brunswick (12)
Howley, B. M., 419 George st., N. Brunswick (12)
Hubbard, Fayette E., 65 Chureh st., Montclair (7)
Hubbard, H. H. V., 121 E. 7th st., Plainfield (20)

Hubbard, Robt. Y., 58 Myrtle av., Irvington (7)
Hubbard, S. T., Hackensack (2)
Huber, Wm. H., 15 Salem st., Newark (7)
Huberman, John, 853 S. 12th st., Newark (7)
Hubert, Antonio, 134 Main st., Rockaway (14)
Hudson, W. J., 39 W. Wash'ton av., Pleasantv'le(1)
Huff, Edmund N., Englewood (2)
Hughes, Frank R., Cape May (5)
Hughes, Fred'k J., 706 Park av., Plainfield (20)
Hughes, Lee W., 965 Broad st., Newark (7)
Hughes, Thomas E., 223 Cooper st., Camden (4)
Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
Hull, D. B., Ridgewood (2)
Hummel, Ernest G., 414 Cooper st., Camden (4)
Hummel, L. C., Salem (17)
Hummel, L. H., Salem (17)
Hummel, Merwin L., 135 N. Centre, M'rch'tv'le (4)
Humphries, Robt. E., 637 Central av., E. Orange (7)
Hunt, A. C., 625 Middlesex av., Metuchen (12)
Hunt, Geo. Halsey, Broad st., Red Bank (13)
Hunt, M. M., 16 Jackson st., South River (12)
Hunter, Edward R., Delanco (3)
Hurff, Joseph W., 86 Washington st., Newark (7)
Husserl, Siegfried, 777 Clinton av., Newark (7)
Husted, S. H., Neshanic (18)
Hutcheson, Chas. R., 517 Cooper st., Camden (4)
Hutchinson, A. D., 913 W. State st., Trenton (11)
Hyman, Charles, 1616 Pacific av., Atlantic City (1)

Associate Members

Hollywood, Jas. L., 34-A Bartholdi av., Jer. C'y (9)
Hunter, Floyd D., Hamilton Sq. (11)
Hutchinson, Geo. E., Hamilton Sq. (11)

Iams, Samuel H., 34 Mercer st., Princeton (11)
Ignatoff, M. L., 493 Central av., Newark (7)
Ill, Carl H., 188 Clinton av., Newark (7)
Ill, Charles L., 188 Clinton av., Newark (7)
Ill, Edgar Alex., 1002 Broad st., Newark (7)
Ill, Edmund W., 188 Clinton av., Newark (7)
Ill, Edward J., 1004 Broad st., Newark (7)
Ill, Herbert M., 188 Clinton av., Newark (7)
Imbleau, J. E. L., Morris av., Union (20)
Imhoff, R. E., Moorestown (3)
Inge, Theo. R., 336 Halsted st., E. Orange (7)
Ingling, Harry W., Freehold (13)
Introcaso, D. A., 45 Crescent av., Jersey City (9)
Ireland, Milton S., 23 S. Cal. av., Atlantic City (1)
Irwin, Jas. R., 330 Washington av., Belleville (7)
Irwin, J. H., Englewood (2)
Irvin, John S., 1910 Pacific av., Atlantic City (1)
Irving, Albert, 758 Main av., Clifton (16)
Iserman, M., 376 Elmora av., Elizabeth (20)
Ishkhanian, N. J., 656 Palisade av., W. N. York (9)
Ivins, W. C., 214 E. Hanover st., Trenton (11)
Izenberg, David, 158 Hamilton av., Paterson (16)

Associate Members

Ireland, Allen G., State Dept. Education,Tr'nt'n(11)
Israeloff, Howard M., 7 Frederick ter., Irvington (7)

Jack, H. Wesley, 920 Haddon av., Collingswood (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Albert F., 225 Hillside av., Nutley (7)
Jackson, Chas. H., 1250 Park Blvd., Camden (4)
Jackson, G. H., 1030 Pine st., Union (20)
Jackson, E. C., 98 Washington st., E. Orange (7)
Jacob, Albert N., Sparta (19)
Jacobsen, J. Jos., 1616 Pacific av., Atlantic City (1)
Jacques, J. Eugenia, 74 Waverly st., Jer. City (9)
Jaffee, Herman, 112 Bergen av., Jersey City (9)
Jaffin, Abraham E., 41 Emory st., Jersey City (9)
Jahn, Albert, Pas. Nat. Bank, Passaic (16)
James, Bart M., 31 Lincoln Park, Newark (7)
James, Henry C., May's Landing (1)
James, William H., Pennsville (17)
James, W. L., Englewood (2)
Jamison, W. F., 501 Grand av., Asbury Park (13)
Janifer, Clarence S., 208 Parker st., Newark (7)
Japhe, Nathaniel, 147 Market st., Perth Amboy (12)
Jarrett, Harry, 925 Broadway, Camden (4)
Jaspan, Samuel C., 320 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jentz, John H., 63 Sherman pl., Jersey City (9)
Jessurun, S. H., 613 High st., Newark (7)
Joelson, Morris S., 670 14th av., Paterson (16)
Johnsen, S. W., 49 Passaic av., Passaic (16)
Johnson, Charles H., 632 Benson st., Camden (4)
Johnson, F. C., 51 Livingston av., N. Brunsw'k (12)
Johnson, George, Branchville (19)
Johnson, G. L., Englewood (2)
Johnson, George L., Morristown (14)
Johnson, H. F., 915 Kensington av., Plainfield (20)
Johnson, J. F., 209 Main st., Chatham (14)
Johnson, V. Earl, 101 S. Indiana av., Atl. City (1)
Johnston, R. O., Harrington Park (2)
Johnston, S. F., Rochelle Park (2)
Jones, J. Morgan, 317 Prospect st., Ridgewood (9)
Jones, E. C., 75 Midland av., Montclair (7)
Jones, Lewis H., 139 Grant av., Roselle Park (20)
Jordan, J. C., Manasquan (13)
Jordan, W. L., Englewood (2)
Joseph, B. M., 50 Glenwood av., Jersey City (9)
Joseph, Morris, 271 Lexington av., Passaic (16)
Jonitz, Robert, 157 S. Grove st., E. Orange (7)
Judge, John F., 1009 S. Orange av., Newark (7)
Jukofsky, I. D., Ridgefield Park (2)
Just, Francis, 564 High st., Newark (7)
Justin, A. W., 41 Fulton st., Weehawken (9)
Justin, J. C., 413 16th st., W. New York (9)

Associate Members

Jenson, Grover H., 169 Lexington av., Jer. City (9)

Kachdorian, Vartan, 930 Brunswick av., Trent'n(11)
Kahrs, Grace M., 375 Mt. Prospect av., Newark (7)
Kaighn, Chas. B., 905 Pacific av., Atlantic City (1)
Kain, Thomas M., 403 Cooper st., Camden (4)
Kain, Wm. W., Cape May C't H'se, R.F.D. 1 (4)
Kalb, S. W., 416 Clinton pl., Newark (7)
Kalter, Geo. E., 640 Prospect st., Maplewood (7)
Kane, Chas. J., 349 Grant st., Paterson (16)
Kaplan, Herman B., 324 44th st., Union City (9)
Kapp, Carl G., 410 Westminster av., Elizabeth (20)
Karshmer, N., 422 George st., New Brunswick (12)
Kastler, F., Rutherford (2)
Kauffman, Louis J., Millville (6)
Kaufhold, Frank, 41 Leslie st., Newark (7)
*Kaufman, Ignatz, Newark (7)
Kaufman, Jerome G., 299 Clinton av., Newark (7)
Kaufman, M. J., 103 Lyons av., Newark (7)
Kavanaugh, D. E., 252 Washington av., Bellev'le (7)
Kay, Clarence R., Peapack (18)
Kazman, Harold A., 406 Broadway, L. Branch (13)
Kearney, John V., 410 Bergenline av., Union C'y(9)
Kearney, Edward P., 26 Forest st., Montclair (7)
Keating, C. A., 177 Ellison st., Paterson (16)
Keck, William F., Cape May (5)
Keegan, Thos. D., 117 Kensington av., Jer. City (9)
Keim, William F., 25 Roseville av., Newark (7)
Keir, Floyd E., Englewood (2)
Keller, F. J., 795 Broadway, Paterson (16)
Keller, Sidney C., 31 Lincoln Park, Newark (7)
Kelley, Chas. B., Trust Co. of N. J. Bldg., Jer.C'y(9)
Kelly, Bernard S., 1954 Blvd., Jersey City (9)
Kelly, James E., 1885 Boulevard, Jersey City (9)
Kemeny, Mere, Cartaret (12)
Kemper, Harry T., 225 Orchard st., Elizabeth (20)
Kennedy, P. A., Englewood (2)
Kenney, C. B., Fairlawn (2)
Kenney, J. A., 132 W. Kinney st., Newark (7)
Kent, M. M., 233 N. Warren st., Trenton (11)
Kenyon, H. M., Bergenfield (2)
Kerdasha, Geo. S., 131 31st st., N. Bergen (2)

Kern, E. Clarence, 45 Park st., Montclair (7)
Kerns, Francis J., 556 Warren st., Newark (7)
Kessler, Henry B., 666 Clinton av., Newark (7)
Kessler, Henry H., 31 Lincoln Park, Newark (7)
Kice, Henry W., Wharton (14)
Kiley, Eugene M., 730 Hudson st., Hoboken (9)
Kiley, J. E., 31 Lincoln Park, Newark (7)
Kieney, C. B., 137 Summit av., Summit (20)
Kilduffe, Robert A., 5003 Atl. av., Ventnor (1)
Kim, Gay Bong, St. Joseph Hosp., Paterson (16)
Kinch, Fred A., 267 E. Broad st., Westfield (20)
King, Alden P., Succasunna (14)
King, Chester A., Oradell (2)
King, George W., Laurel Hill, Secaucus (9)
Kingslow, G. L., Hackensack (2)
Kinney, A. G., 249 Woodl'd ter., Collingswood (4)
Kinney, S. T., 250 Main st, South Amboy (12)
Kirby, Cyril S., 98 Broad st., Bloomfield (7)
Kirkman, Leroy G., 176 Roseville av., Newark (7)
Kirkwood, Allan S., 53 Union st., Montclair (7)
Klaus, Henry, 435 Palisade av., Union City (9)
Kleiber, Estella, 139 New st., New Brunswick (12)
Klein, Edward C., Jr., 209 Littleton av., Newark (7)
Klein, E. F., 136 Market st., Perth Amboy (12)
Klein, Ignatz, 471 Springfield av., Newark (7)
Klein, Wm., 85 Bayard st., New Brunswick (12)
Kleinman, Maurice, 2 Farley av., Newark (7)
Klenk, J. P., 328 Belleville av., Bloomfield (7)
Kler, J. H., Reed st., Stelton (12)
Kline, Oram R., 414 Cooper st., Camden (4)
Klugman, Louis W., 375 Ave. C, Bayonne (9)
Knapp, Richard E., Hackensack (2)
Knauer, Geo., 930 Elizabeth av., Elizabeth (20)
Knepper, Orcena F., 149 Crescent av., Pl'nf'ld (20)
Knight, Augustus S., Far Hills (18)
Knight, I. Warner, Pitman (8)
Knowles, G. M., Ridgefield Park (2)
Knowles, James S., Millville (6)
Knox, C. A., Ridgefield Park (2)
Knox, Harriet L., Hackensack (2)
Knox, Howard A., New Hampton (10)
Koelsch, F. J., Bayard st., New Brunswick (12)
Koerber, Geo., 136 Prospect st., Passaic (16)
Kolb, J. M., 725 10th st., Union City (9)
Kolodin, A., 147 Franklin st., Bloomfield (7)
Konzelman, H. J., 50 King st., Hillside (20)
Kooperman, Benj., 221 16th st., W. New York (9)
Kooperstein, Samuel, 395 Odgen av., Jer. City (9)
Koplin, N. H., 142 W. State st., Trenton (11)
Koppel, Joseph, 921 Bergen av., Jersey City (9)
Koppel, Leo A., 921 Bergen av., Jersey City (9)
Kossmann, Walter J., Pompton Plains (14)
Kovarsky, A. E., 255 State st., Perth Amboy (12)
Kovin, A., 123 Lexington av., Passaic (16)
Kowalski, Louis J., 64 Fourth st., Passaic (16)
Kraczyk, M. J., 207 Whitehead av., N. Brunsw'k(12)
Kraemer, Manfred, 186 Clinton av., Newark (7)
Kraissl, C., Englewood (2)
Kraker, David A., 31 Lincoln Park, Newark (7)
Kralikauckas, Jos. K., 164 Park pl., Elizabeth (20)
Kraemer, S. E., 121 Market st., Perth Amboy (12)
Krans, Clara DeH., 920 Park av., Plainfield (20)
Krans, Edw. S., 920 Park av., Plainfield (20)
Krauss, Emory, Phillipsburg (21)
Krauss, Fletcher I., Chatham (14)
Krechmer, Abraham, 521 Pacific av., Atl. City (1)
Kresch, Philip, 42 W. 22d st., Bayonne (9)
Krichbaum, Carroll E., 63 Myrtle av., Montclair (7)
Krone, W. F., 31 Lincoln Park, Newark (7)
Kuder, Joseph M., Mount Holly (3)
Kuhl, Paul E., 48 N. Clinton av., Trenton (11)
Kuhlmann, Alvin E., 527 37th st., Union City (9)
Kuite, George B., Morris Plains (14)
Kummel, M., 315 Central av., E. Newark (7)
Knshner, Alexander, 48 Jacques av., Rahway (20)
Kutner, Chas., 1005 S. 5th st., Camden (4)

ASSOCIATE MEMBERS

Kleinman, Maurice, 845 Clinton av., Newark (7)
Kustrup, J. F., 2381 S. Broad st., Trenton (11)

Laatsch, C. E. F., Greystone Park (14)
Laauwe, H., 198 Haledon av., Paterson (16)
Labow, J. J., 1050 E. Jersey st., Elizabeth (20)
Lafferty, Elton B., 149 Harrison st., E. Orange (7)
Laird, Geo. S., 127 Central av., Westfield (20)
Lambert, F. E., 157 Ocean av., Jersey City (9)
*Lamson, Wm. J., 120 Summit av., Summit (20)
Lance, E. W., 98 W. Milton av., Rahway (20)
Lane, Arthur K., Greystone Park (14)
Lane, Austin W., 98 Prospect st., East Orange (7)
Lane, E. W., Bloomsbury (10)
Lane, Frank B., 53 Woodland av., East Orange (7)
Landis, Edwin W., Stillwater (19)
Lange, Louis C., 50 Clifton ter., Weehawken (9)
Larkin, Jos. J., 546 Bramhall av., Jersey City (9)
Larossa, Ernest A., 701 Cooper st., Camden (4)
Largay, Arthur O., 937 Ave. C, Bayonne (9)
La Riew, Fred J., Washington (21)
Larkey, Charles J., 700 Ave. C, Bayonne (9)
Larkin, Jos. J., 546 Bramhall av., Jersey City (9)
Larrabee, C. H., 30 Beechwood rd., Summit (20)
Larson, H. M., 36 Franklin st., Morristown (14)
Lathrop, Frederick W., 507 Park av., Plainfield (20)
Lathrope, Geo. H., 965 Broad st., Newark (14)
Lavine, B. D., 630 N. Clinton av., Trenton (11)
Lawrence, Minnie J., 83 Second av., Newark (7)
Lawrence, Wm., Jr., 129 Summit av., Summit (20)
Lawsing, G. Condi, 443 22d st., W. New York (9)
Lawton, Anderson A., Somerville (18)
Leaver, Morris H., Quakertown (10)
LeBel, Louis J. B., 165 Grant av., Nutley (7)
Leddecke, Rowland E., E. Rutherford (2)
Lee, Stephen G., 55 Halsted st., East Orange (7)
Lee, Thomas B., 622 Cooper st., Camden (4)
LeFavor, Dean H., Palmyra (3)
Lefkowitz, Jacob H., 445 20th st., W. N. York (9)
Leff, Charles O., 83 Farley av., Newark (7)
Leggett, L. H., 330 E. Broad st., Westfield (20)
Leggett, T. H., Jr., 706 Park av., Plainfield (20)
*Lehlbach, C. F., U. S. Sea S., 157 Cedar st., N. Y. (7)
Lehmacher, Frank, Lakewood (15)
Leighton, R. L., 401 Ludlow av., Spring Lake (13)
Leining, Albert, 1 Fourth st., Weehawken (9)
Lemmerz, T. H., 141 Magnolia av., Jersey City (9)
Leonard, E. A., 81 Park av., Paterson (16)
Leonard G. F., 63 N. 5th av., New Brunswick (12)
Leonard, Isaac E., 2842 Atlantic av., Atl. City (1)
Leonard Lothair L., 615 Asb'y av., Asb'y Park (13)
Leonardis, J. V., 94 Jefferson st., Newark (7)
Lerman, I., 1024 E. Jersey st., Elizabeth (20)
Lettiere, A. J., 320 Centre st., Trenton (11)
Levin, Joseph, 831 S. 13th st., Newark (7)
Levin, Louis, 140 W. State st., Trenton (11)
Levin, M. L., 209 Avon av., Newark (7)
Levine, D. B., 282 Broadway, Paterson (16)
Levine, G. I., 1861 Boulevard, Jersey City (9)
Levine, Israel, 106 Bowers st., Jersey City (9)
Levine, Israel, 215 Broadway, Paterson (16)
Levine, S. C., 459 Park av., Paterson (16)
Levinson, L. J., 190 Clinton av., Newark (7)
Levinsohn, S., 584 B'way, Paterson (16)
Levitas, Geo. M., Westwood (2)
Levitt, Jesse N., 26 Clinton pl., Newark (7)
Levy, A., Somerville (18)
Levy, Herman, 219 Lexington av., Passaic (16)
Levy, Julius, 66 Baldwin av., Newark (7)
Lewandowski, S. S., 1450 Mt. Ephraim av., C'md'n(4)
Lewis, Albert, 41 Retford av., Cranford (20)
Lewis, Alice B., Saddle River (2)
Lewis, Geo. R., 458 Washington av., Belleville (7)
Lewis, Livingston L., 712 Wash. st., Hoboken (9)
Lewis, Thos. K., 47 S. 27th st., Camden (4)
Leyenberger, S. B., 310 Mt. Prospect av., N'w'k (7)
Lieberman, David P., 1072 North av., Elizabeth(20)

Lilien, M. M., 162 Gruman av., Hillside (20)
Linares, A. C., 402 Market st., Paterson (16)
Linden, Mortimer H., 45 Clendenny av., Jer. C'y (9)
*Lindley, C. H., 4047 Marathon av., L. Angeles (15)
Lindroth, Lawrence V., 4633 Hudson Blvd., J. C. (9)
Lippincott, A. Haines, 406 Cooper st., Camden (4)
Lipton, L., 67 Passaic av., Passaic (16)
Little, William R., Pennington (11)
Little, Alonzo W., 120 Arlington av., Jer. City (9)
Littwin, Charles, Englewood (2)
Liva, Archangelo, 5 Pangborn pl., Hackensack (2)
Liva, P. F., Lyndhurst (2)
Livengood, B. A., Swedesboro (8)
Livengood, H. R., 587 Westminster av., Eliz'b'th(20)
Livingston, J., 71 Baldwin av., Newark (7)
Livingston, Paul, 299 Main st., East Orange (7)
Lloyd, Reba (Kumpf), Bridgeton (6)
Lobsenz, N., 294 Broadway, Paterson (16)
Lodas, George, 1141 E. Jersey st., Elizabeth (20)
Loder, Horace B., Bridgeton (6)
Loder, Joseph S., 924 S. 17th st., Newark (7)
Loeser, Lewis H., 31 Lincoln Park, Newark (7)
Lomauro, Jas. R., 70 Grove st., Passaic (16)
London, Wm. M., 256 State st., Perth Amboy (12)
Londrigan, J. F., 1000 Hudson st., Hoboken (9)
Long, Herb. W., 102 Jefferson st., Newark (7)
Long, Miles T., 2150 Boulevard, Jersey City (9)
Long, Pauline A., 20 Liv'gst'n av., N. Brunsw'k(12)
Long, William H., Jr., Somerville (18)
Longbothum, G. T., Washington av., Dunellen (12)
Longsdorf, Harold E., Mount Holly (3)
Loori, William, 549 Pavonia av., Jersey City (9)
Loper, John G., Bridgeton (6)
Lore, Harry E., Bridgeton (6)
Losada, Camella A., 19 Prospect st., Summit (20)
Lottridge, Dorothy, 43 S. Maple av., E. Orange (7)
Love, Elizabeth F., Moorestown (3)
Lovett, Irving K., 110 E. Front st., Red Bank (13)
Lovett, Jos. C., Municipal Hospital, Camden (4)
Lovejoy, J., Bound Brook (18)
Low, Donald B., 529 Broadway, Paterson (16)
Lowell, M. E., 434 Summit av., Westfield (20)
Lowenstein, H. A., 96 Milford av., Newark (7)
Lowitz, Otto, 78 Clinton av., Newark (7)
Lowrey, James H., 79 Congress st., Newark (7)
Lowy, Otto, 190 Clinton av., Newark (7)
Luban, Benjamin, 730 High st., Newark (7)
Lucas, H. H., 266 Van Houten st., Paterson (16)
Lucent, S. Bell, Little Falls (16)
Luczynski, Edward, 38 W. 26th st., Bayonne (9)
Leddecke, Rowland E., E. Rutherford (2)
Lufburrow, C. B., 411 W. Front st., Plainfield (20)
Luippold, E. J., 85 Columbia ter., Weehawken (9)
Lumis, M. F., Pitman (8)
Lummis, C. Percy, Bridgeton (6)
Lund, John L., 267 High st., Perth Amboy (12)
Lundblad, Walt. E., 75 Prospect st., E. Orange (7)
Luonogo, F., 212 S. Centre st., Orange (7)
Lupin, Edward E., 727 Ave. C, Bayonne (9)
Lynch, A. E. O., 257 Orange rd., Montclair (7)
Lynch, M. M., Hackensack (2)
Lynch, Roland J., 93 Fairview av., Jersey City (9)
Lyon, Archibald, 115 Ridge rd., Arlington (7)
Lyon, C. H., Phillipsburg (21)
Lyon, C. V., Phillipsburg (21)
Lyon, Earl Crosby, Bridgeton (6)
Lyon, Leslie C., P. O. Box 63, Magnolia (4)
Lyons, James V., 333 Park av., Orange (7)
Lyons, S. R., Engiewood (2)

Associate Members

Legate, S. F., 402 Anderson av., Cliffside (2)
Levinson, R. M., 369 S. 12th st., Newark (7)
Leir, J. Krevin, 9 Garrison av., Jersey City (9)
Light, Arthur S., Lawrenceville (11)
Lucas, W. Fred., 115 Van Wagenn av., Jer. C'y (9)
Lynn, Irving I., 272 Banow st., Jersey City (9)
Macalister, Alexander, 626 Federal st., Camden (4)
MacAlister, W. W., 333 Van Houten, Paterson (16)
MacAlpine, Ken. B., 533 Monm'th st.,Gl'c'st'r C'y(4)
MacArthur, Clymont, 219 Roseville av., Newark (7)
Macauley, F. A., Tenafly (2)
Macchia, Benj. J., 262 Montgomery st., Jer. City (9)
MacDermid, Lynden E., Bordentown (11)
Macdonald, W. S., 56 Church st., Montclair (7)
MacDowell, J. L., 112 State st., Perth Amboy (12)
MacFarland, B. W., Br'd St. B'k Bldg., Tr'nt'n (11)
MacGregor, A., 379 Ellison st., Paterson (16)
Mackellar, James M., Tenafly (2)
MacKenzie, R. A., 501 Grand av., Asbury Park (13)
MacMillan, Wright, 23 Passaic av., Passaic (16)
MacPherson, Elwood H., 12 R'wl'y pl., Millburn (7)
McArthur, Chas., 5 Elm st., S. Orange (7)
McBride, Andrew F., 30 Church st., Paterson (16)
McBride, Hesser G., 1072 S. Or. av., Newark (7)
McCabe, Thomas S., 913 Broad st., Newark (7)
McCallion, W. H., 722 Westminster av., Eliz. (20)
McCamey, Kenneth E., 174 Carroll st., Paterson (16)
McCarthy, Arthur M., 2772 Federal st., Camden (4)
McCarthy, Geo. L., 496 Union av., Paterson (16)
McCauley, Francis J., 31 Lincoln Park, Newark (7)
McClintock, Elsie, 1435 Mapes av., Hillside (20)
McCollum, A. S., 213 Clements Br. rd. ,B'rringt'n(4)
McConaghy, Th. P., SW.cor.10th&C'p'r sts.,C'md'n(4)
McConaughy, Francis, Somerville (18)
McConnell, C. W., Keansburg (13)
McCorkle, W. E., Ringoes (10)
McCormick, Jas. E., 322 Clinton av., Newark (7)
McCormack, F. C., Englewood (2)
McCormick, W. H., 266 Market st., P. Amboy (12)
McCoy, John C., 292 Broadway, Paterson (16)
McCollough, J. H., 523 E. State st., Trenton (11)
McCoullough, W. A., Essex Co. Hosp., Cedar Gr.(7)
McCroskery, J. H., 396 N. Arlington av., E. O. (7)
McDannald, William S., Tenafly (2)
McDede, E. H., Lyndhurst (2)
McDede, Frank F., 922 Main st., Paterson (16)
McDede, Jos. Searle, 215 Ege av., Jersey City (9)
McDermott, Vincent, 511 State st., Camden (4)
McDonald, F. R., 79 Summit av., Jersey City (9)
McDonald, J. O., 194 W. State st., Trenton (11)
McDonald, Richard J., 294 Broadway, Paterson (14)
McDonnell, G. E., Mt. Holly (3)
McDowell, G. E., Mt. Holly (3)
McElhinney, Dennis R., 110 W. Jer. st., Eliz. (20)
McElroy, Ervin, Rockaway (14)
McEwen, Floy, 299 Broadway, Newark (7)
McFeeley, P. R., Bogota (2)
McGeehan, Stanley M., Ryanhurst Apts., Atl. C'y(1)
McGinn, W. J., Front st., Scotch Plains (20)
McGovern, J. F., 24 Livingston av., N. Bruns. (12)
McGuire, James J., 122 W. State st., Trenton (11)
McGuigan, F. A., 212 N. Warren st., Trenton (11)
McKim, Wm. F., 1044 S. Orange av., Newark (7)
McKiernan, Robt. L., 97 Bayard st., N. Bruns. (12)
McKinstry, Frank P., Washington (21)
McKinstry, J. W., Jamesburg (12)
McLean, Herbert E., 92 Fairview av., Jer. City (9)
McLean, Hugh A., 414 17th st., W. New York (9)
McLean, John J., 92 Fairview av., Jersey City (9)
McLellan, Geo. A., 19 Hawthorne av., E. Orange (7)
McLeod, H. J., Englewood (2)
McLeod, N. S., Highland Park (12)
McLoughlin, F. J., 558 Jersey av., Jersey City (9)
McMahon, Bernard S., Morristown (14)
McMurray, George B., Greystone Park (14)
McMurtrie, W. A., 26 Maple av., Morristown (14)
McNenney, C. E., 113 Fairview av., Jer. City (9)
McPherson, M. G., 171 Dia. Br. av., Hawthorne (16)
McVay, Edward A., 234 Lafayette st., Newark (7)

Maas, M. A., 329 Clinton av., Newark (7)
Mabey, J. C., 242 Claremont av., Montclair (7)
Mace, Margaret, N. Wildwood (5)

Maciejewski, A. S., 212 Van Buren st., Newark (7)
*Mack, George L., Bound Brook (18)
Mackellar, James M., Tenafly (2)
Mackes, C. L., Woodstown (17)
Mackler, Louis, 705 Pacific av., Atlantic City (1)
Maclay, Joseph A., 463 E. 29th st., Paterson (16)
Madaras, John F., 907 Ave. C, Bayonne (9)
Madden, T. W., 16 Frazer av., Collingswood (4)
Madden, Leland S., Verona av., Pleasantville (1)
Madden, Wm. L., 30 Kensington av., Jersey City (9)
Mader, A. I., Hackensack (2)
Magennis, B. C., 170 Hamilton av., Paterson (16)
Magill, Marcus, 4116 Ventnor av., Atlantic City (1)
Mahaffey, Jesse L., 542 Cooper st., Camden (4)
Maher, John E., 90 Third av., Long Branch (13)
Mahood, H. L., 86 Durand rd., Maplewood (7)
Makin, John B., 501 Grand av., Asbury Park (13)
Malatesta, C. S., 741 Kingston av., Plainfield (20)
Malavazos, Antonio, 635 High st., Newark (7)
Maldeis, A. M. K., 117 N. 6th st., Camden (4)
Maliniak, Jacques W., 31 Lincoln Pk., Newark (7)
Mallalieu, F. W., 16 Monticello av., Jer. City (9)
Mamlet, Alfred M., 16 Johnson av., Newark (7)
Manahan, D. V., 55 E. Front st., Red Bank (13)
Mancusi-Ungaro, E., 270 Mt. Prospect av., Nwk. (7)
Mancusi-Ungaro, L., 156 Mt. Prospect av., Nwk. (7)
Manglesdorf, A. F., 565 Belgrove dr., Arlington (7)
Mangone, Geo. F., 171 Palisade av., Union City (9)
Manley, F., 390 Park av., Paterson (16)
Mann, Jacob J., 255 State st., Perth Amboy (12)
Maps, Howard L., 53 Passaic av., Passaic (16)
Maras, Peter E., 80 Tonnele av., Jersey City (9)
Marcus, Jos H., 1148 Fifth av., N. Y. City, N. Y. (1)
Marcus, Alexander, 466 Ferry st., Newark (7)
Marcarian, Henry B., 904 Cooper st., Camden (4)
Marcy, Alexander, Jr., Riverton (3)
Marini, D., 40 Henry st., Passaic (16)
Mark, Joseph S., 102 Green st., Woodbridge (12)
Markel, A., 320 Broadway, Paterson (16)
Markley, L. A., Teaneck (2)
Markowitz, B. B., 2157 Blvd., Jersey City (9)
Markowitz, Irwin, 2157 Boulevard, Jersey City (9)
Marks, David M., 298 4th st., Jersey City (9)
Marks, Edward G., 655 Kearny av., Arlington (7)
Marks, S. J., Bordentown (3)
Marotte, Chas. L., 1417 Clinton av., Trenton (1)
Marquis, Dean W., 132 N. Arlington av., E. Or. (7)
Marquis, W. James, 198 Clinton av., Newark (7)
Marrone, John A., 233 Bowers st., Jer. City (9)
Marshak, Martin, 679 Ave. C, Bayonne (9)
Marsh, E. J., 400 Van Houten st., Paterson (16)
Marshall, Jos. C., 1517 Pacific av., Atlantic City (1)
Marshall, Frank A., 200 Jane st., Weehawken (9)
Martin, William, 117 S. Illinois av., Atl. City (1)
Martin, William P., 25 Holland rd., S. Orange (7)
*Martine, F. L., 182 Roseville av., Newark (7)
Martinetti, Carlo D., 311 Central av., Orange (7)
Martland, Harrison S., 180 Clinton av., Newark (7)
Marvin, Dorothy, 51 Livingston st., N. Br'nsw'k (12)
Mason, Howard B., 90 W. Main st., Freehold (13)
Mason, Jas. H. 3d, 1616 Pacific av., Atlantic City (1)
Massey, John F., 20 S. Newport av., Ventnor (1)
Masucci, A., 34 Ward st., Paterson (16)
Matera, Joseph, 506 Garden st., Hoboken (9)
Matheke, O. G., 328 Sussex av., Newark (7)
Mathesheimer, J. L., 280 Old B'rg'nl'n rd., Jer. C. (9)
Mathews, R. H., 186 South st., Morristown (14)
Mathews, William, Broad st., Red Bank (13)
Matthews, H. E., 504 Hillside av., Orange (7)
Matthews, Leonard M., 657 Main av., Passaic (16)
Matthews, W. F., 11 Seymour av., Montclair (7)
Matthews, Wm. J., 938 Hudson st., Hoboken (9)
Maturi, V. E., 814 Boulevard, Bayonne (9)
Mayer, Wm. W., 532 Bergen av., Jersey City (9)
May, Ernst A., 965 Broad st., Newark (7)
Mayhew, Charles H., Millville (6)
Meacham, E. A., 112 Stevens st., S. Amboy (12)
Mead, Walter G., 699 Kearny av., Arlington (9)
Means, P. B., State Hospital, Trenton (11)
Mears, W. G., Englewood (2)
Mecray, Paul M., 405 Cooper st., Camden (4)
Medd, John C., 25 Curtis pl., *Maplewood (7)
Meehan, George Edw., 117 Mercer st., Jer. City (9)
Meehan, Martin M., 201 Joralemon st., Bellev'le (7)
Meeker, I. A., 581 Valley rd., Upper Montclair (7)
Meeker, Frank B., 355 Clifton av., Newark (7)
Meier, William, Haskell (16)
Meigh, Josiah, Bernardsville (18)
Meinzer, Martin S., 284 Madison av., P. Amboy (12)
Mellen, S. H., 863 Mt. Prospect av., Newark (7)
Meloney, Lester F., 156 2d st., Clifton (16)
Meltsner, L., 904 Hudson st., Hoboken (9)
Mendelsohn, D. H., 576 Broadway, Paterson (16)
Mendelsohn, Lewis, 272 Montgomery st., Jer. C'y (9)
Mendelson, Abraham, 68 Treacy av., Newark (7)
Mendenhall, Clinton D., Bordentown (3)
Meneve. A., 87 Bridge st., Paterson (16)
Mengel, Willard G., 400 Penn av., Camden (4)
Menk, Paul E., 31 Lincoln Park, Newark (7)
Mentzer, C. A., 42 Hollywood av., Hillside (20)
Merendino, Anth. G., 2707 Pacific av., Atl. City (1)
Merrill, C. F., 16 S. 3d av., Highland Park (12)
Merselis, John G., 110 Irvington av., S. Orange (7)
Merschemier, C. H., 15 Reservoir av., Jer. City (9)
Messinger, Samuel J., Chrome (12)
Metzer, Emma P. W., Riverside (3)
Meurlin, Alfred, 158 Harrison st., E. Orange (7)
MeVay, Jas. C., 2907 Pacific av., Atlantic City (1)
Meyer, Edw. H., Mahwah (2)
Meyer, Eugene A., Moorestown (3)
Meyer, George P., 410 Haddon av., Camden (4)
Meyer, H. N., 141 Central av., Maywood (2)
Meyer, Wm., 436 New York av., Union City (9)
Meyers, F. R., 80 Park av., Paterson (16)
Miat, Leon'das L., 38 Elm st., Morristown (14)
Michela, Luigi S., 206 Carroll st., Paterson (16)
Michell, George, 221 High st., Hackettstown (14)
Miller, Earle K., 2502 Nottingham way, Tr'nt'n (11)
Miller, G. H., Cranbury (11)
Miller, Jos. A., 364 Prospect st., S. Orange (7)
Miller, Louis H., Woodstown (17)
Miller, M. H., 311 16th st., West New York (9)
Miller, H. Garrett, Millville (6)
Miller, I. Irwin, 193 Richelieu ter., Newark (7)
Miller, Robt. M., 382 Springfield av., Summit (20)
Miller, Thos. B., Butler (14)
Mills, Alvah V., Lindsley rd., Little Falls (16)
Mills, Charles S., Riverton (3)
Minard, E. L., 140 4th av., East Orange (7)
Miner, Donald, 921 Bergen av., Jersey City (9)
Minier, Carl L., 171 Ellery st., Newark (7)
Minnefor, C. A., 126 Carolina av., Newark (7)
Minningham, Wm. D., 18 Hedden ter., Newark (7)
Mishell, Dan. R., 730 Prospect st., Maplewood (7)
Missonellie, Wm., 404 Lafayette av., Hawthorne (16)
Mitchell, Augustus J., 59 South st., Newark (7)
Mitchell, C. H., 1100 W. State st., Trenton (11)
Mitchell, Chas. R., 311 Broadway, Paterson (16)
Mitskas, T. V. J., Crosswicks (11)
Mockridge, O. A., 8 S. Mountain av., Montclair (7)
Moffat, Barclay W., Nut Swamp rd., Red Bank (13)
Moister, Roger W., 30 Beechwood rd., Summit (20)
Monoghan, William J., Secaucus (9)
Montifort, R. J., 1051 E. Jer st., Elizabeth (20)
Moore, John D., 6 Washington av., Bloomfield (7)
Moore, Ralph L., Woodbury (8)
Moore, Wm. G., 1576 Mt. Ephraim av., Camden (4)
Morgan, Browne, 260 Liberty st., Bloomfield (7)
Moriconi, A. F., 438 Hamilton av., Trenton (11)
Moriss, Edward J., 1501 Maple av., Hillside (20)
Morley, Grace C., 440 Palisade av., Weehawken (9)
Morris, Carlysle, Metuchen (12)
Morris, Clement, 513 Broadway, Newark (7)
Morris, D. G., 11 W. 26th st., Bayonne (9)

Morris, Thos. M., 503 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Millburn (20)
Morrison, Caldwell, 379 7th av., Newark (7)
Morrison, Frederick H., Newton (19)
Morrison, J. Bennett, 66 Milford av., Newark (7)
Morrill, Jas. P., 310 Broadway, Paterson (16)
Morrow, Jos. R., Isolation Hospital, Oradell (2)
Mosher, H. L., Lyndhurst (2)
Motzenbecker, P. F., 31 Lincoln Park, Newark (7)
Motzenbecker, Wm. J., 16 Milford av., Newark (7)
Moulton, Chas. D., 122 Park av., East Orange (7)
Mount, Elmer, 74 Sherman pl., Jersey City (9)
Mount, W. B., 21 Plymouth, Montclair (7)
Mras, J. N., State Hospital (11)
Mravlag, Victor, 1064 E. Jersey st., Elizabeth
Mueller, Geo. H., 102 Summit av., Jersey City (9)
Muellerschoen, Geo. J., 220 S. 16th st., Phila., Pa. (1)
Muldoon, Edward J., Florence (3)
Mulford, Ephraim R., Burlington (3)
Muller, F. L., Carlstadt (2)
Mulligan, L. A., Leonia (2)
Mullin, Raymond J., 857 S. 11th st., Newark (7)
Mullins, R. L., 144 Harrison st., E. Orange (7)
Munger, Ray T., 727 Watchung av., Plainfield (20)
Murn, Charles J., 48 Smith st., Paterson (16)
Murphy, Edward A., 1 Britten st., Jersey City (9)
Murphy, Herschel, 130 Grant av., E.,Roselle P'k(20)
Murphy, J. A., 467 Hamilton av., Trenton (11)
Murphy, James M., 2757 Boulevard, Jer. City (9)
Murphy, P. H. W., 27 Jefferson st., Jersey City (9)
Murray, H. A., 624 Mt. Prosp. av., Newark (7)
Murray, Joseph A., 765 Ave. C, Bayonne (9)
Musetto, Carmelo A., Bconton (14)
Mustermann, Otto H., 234 48th st., Union City (9)
Muta, Samuel A., 47 Park av., West Orange (7)
Mutcher, Julia, Butler (14)
Mutchler, Raymond, Butler (14)
Muttart, George W., 702 Ocean av., Jersey City (9)
Mutter, Alfred A., 75 Beach st., Kearny (9)
Myatt, Leslie E., Bridgeton (6)
Myer, Edw. H., Mahwah (2)

Associate Members

McCandliss, W. K., State Hosp., Trenton (11)
McLane, A. Donald, 155 Eagle st., Englewood (2)
Maggio, George A., 110 Fleming av., Newark (7)
Meriweather, E. G., State Hosp., Trenton (11)
Mewborne, Edw. B., Larenceville (11)
Morrison, Benj. G., 500 Marlboro rd., W'dbr'dge (2)

Nafash, M. Shafesk, 402 21st st., Union City (9)
Nafey, Herb't W., 51 Livingston av., N. Bruns. (12)
Nalitt, David I., 28 W. 33rd st., Bayonne (9)
Nappi, P. E., 254 Clifton av., Newark (7)
Nash, Albert B., 10 S. 13th st., Newark (7)
Nash, Alexander E., 20 Forest av., Verona (7)
Nash, Herman S., 865 S. 11th st., Newark (7)
Nataro, Joseph, 172 Littleton av., Newark (7)
Nattrass, R. B., 204 11th st., Hoboken (9)
Naulty, C. W., Jr., 403 High st., Perth Amboy (12)
Nay, Chas. K., 64 Palisade av., Jersey City (9)
Neal, Charles B., Millville (6)
Neare, Clifford B., 2 Hawthorne av., E. Orange (7)
Neer, William, 245 Broadway, Paterson (16)
Ne'son, Aaron, 462 Jersey av., Jersey City (9)
Nelson, Harry, Woodbury (8)
Netz, L. W., Hackensack (2)
Nesbit, Elizabeth, N. J. Train. School, L. Falls (16)
Neves, Charles S., 281 Park st., Montclair (7)
Nevin, John, 921 Bergen av., Jersey City (9)
Newcomb, Marcus W., Brown's Mills (3)
Newman, Ab'ham J., 69 Sherman pl., Jer. City (9)
*Newman, Emanuel D., 81 New st., Newark (7)
Newman, Grace T., 339 Grove st., Montclair (7)
Newman, Louis G., 316 E. Broad st., Westfield (20)
Ney, Charles K., 164 Palisade av., Jersey City (9)
Nichols, Stanley H., 501 Grand av., Asbury P'k (13)
Nicholson, Frank, 895 Summit av., Jersey City (9)
Nickman, Harrison, 101 S. Indiana av., Atl. City (1)
Nicols, F. I., Hackensack (2)
Niemeyer, C. V., 4610 Boulevard, Weehawken (9)
Niemtzow, Frank, 45 E. Main st., Freehold (13)
Niles, Frank Lee, Hackensack (2)
Nittoli, R. N., 660 E. Jersey st., Elizabeth (20)
Noll, Louis, 1044 Clinton av., Irvington (7)
North, Harry R., 160 W. State st., Trenton (11)
Norton, James F., 299 Varick st., Jersey City (9)
Norval, William A., 419 Main st., Paterson (16)
Nowrey, Jos. E., Jr., 431 Vine st., Camden (4)
Nuse, Edward F., 550½ Jersey av., Jersey City (9)
Nye, Howard H., 174 Broadway, Paterson (16)
Nyiri, William, 30 Van Ness pl., Newark (7)

Oakes, A. E., 1158 Mary st., Elizabeth (20)
Obert, J. E., New Egypt (15)
O'Brian, Dennis M., 162 Lexington av., Passaic (16)
O'Brien, Paul, East Rutherford (2)
O'Brien, J. H., 204 Madison pl., Passaic (16)
O'Brion, D. J., 197 Spring st., Portland, Maine (20)
Obuchowski, Henry T., 86 Belmont av., Newark (7)
O'Connor, B. A., 314 N. 4th st., Harrison (9)
O'Connor, D. F., 671 Broad st., Newark (7)
O'Connor, John J., 434 New York av., Union C'y (9)
O'Connor, M. J., 8 Harrison pl., Irvington (7)
O'Crowley, C. R., 31 Lincoln Park, Newark (7)
Ockene, Abraham, 495 Palisade av., Union C'y (9)
Oestman, A. W., 932 Summit av., Jer. C'y Hts. (9)
O'Gorman, M. W., 921 Bergen av., Jersey City (9)
O'Hanlon, George, Jersey City Hospital (9)
Okin, I., 23 Passaic av., Passaic (16)
Older, Benj., 435 N. Y. av., Union City (9)
Oleynick, S., 107 Clinton av., Newark (7)
Oliphant, N. B., 152 W. State st., Trenton (11)
Olini, Jos. J., 30 W. Market st., Newark (7)
Oliver, David H., Bridgeton (6)
Olmstead, W. D., 1710 Pacific av., Atlantic City (1)
Olpp, Archibald E., 318 Bergenline av., Union C'y(9)
Ondovchak, M. F., 1494 Mt. Ephraim av., Camd'n(4)
O'Neill, Charles L., 11 N. 7th st., Newark (7)
O'Neill, John H., 270 Montgomery st., Jer. City (9)
Opdyke, C. P., 10 Summit rd., Verona (7)
Opdyke, Gordon McC., 10 Summit rd., Verona (7)
Opdyke, Levings A., 55 Clinton av., Jersey City (9)
Openchowski, M., 52 Jones st., Newark (7)
Opferman, J. L., Highlands (13)
Oram, Jos. H., 495 Broadway, Paterson (16)
O'Rourke, Jas. J., 871 Stuyvesant av., Trenton (11)
Orloff, Samuel, 97 Lyons av., Newark (7)
Orton, George L., 98 Elm st., Rahway (20)
Orton, Henry B., 24 Commerce st., Newark (7)
O'Shea, John J., 135 Shippen st., Weehawken (9)
Oshrin, Henry, 750 Park av., W. New York (9)
Osmun, Milton M., 611 Broadway, Camden (4)
Ost, Henry, 1109-A Broad st., Newark (7)
Owen, Fred W., 18 Franklin pl., Morristown (14)
Ovens, Richard C., 675 Bergen av., Jersey City (9)
Owens, Logan S., 938 Hudson st., Hoboken (9)

Associate Members

O'Sullivan, John R., 285 Chestnut st., Kearny (9)

Paddock, Royce, 965 Broad st., Newark (7)
Paganelli, T. R., 1006 Garden st., Hoboken (9)
Pagliughi, J. J., 401 18th st., Union City (9)
Pal, D. R., 32 Clark st., Paterson (16)
Palm, Howard F., 614 N. 2d st., Camden (4)
Palma, N., 286 Broadway, Paterson (16)
Palmer, Gideon H., 28 Winans st., E. Orange (7)
Palmer, H. S., 257 Mulberry st., Newark (7)
Panitch, Wm., 352 Belmont av., Newark (7)
Pannullo, J. N., 266 Van Buren st., Newark (7)
Pansy, Abraham, 12 Jackson st., South River (12)
Pantaleone, J., 504 Hamilton av., Trenton (11)
Parent, Sol., 924 S. 20th st., Newark (7)
Parisi, A., 150 Hunterdon st., Newark (7)
Parker, John E., 385 Park av., Orange (7)

Parker, H. N., 72 N. Clinton st., Trenton (11)
Parry, O. K., Electric Bldg., Asbury Park (13)
Parsonnet, Eugene V., 31 Lincoln Park, Newark (7)
Pascall, Thomas M., 197 Lincoln av., Newark (7)
Paul, G. A., 765 Lyons av., Irvington (7)
Paulson, A. M., 106 E. 7th st., Elizabeth (20)
Payawall, J. L., 170 Broadway, Paterson (16)
Payne, Guy, Overbrook Hospital, Cedar Grove (7)
Payne, Joseph, Midland Park (2)
Pearlstein, F., 325 16th st., West New York (9)
Peck, Ellery Newell, Boonton (14)
Pedevill, J., Palisade Park (2)
Pedrick, Charles D., Glassboro (8)
Pedrick, William, Glassboro (8)
Peer, Lyndon A., 965 Broad st., Newark (7)
Pellarin, John D., 493 New York av., Union City (9)
Pellett, T. L., Hamburg (19)
Pelusio, Aug. M., 269 Carroll st., Paterson (16)
Pendexter, S. E., 11 S. Arlington av., E. Orange (7)
Pennington, A. W., 111 Raab av., Bloomfield (7)
Pennington, G. P., 161 Prospect st., E. Orange (7)
Pennington, Geo. P., 12 S. Chelsea av., Atl. C'y (1)
Pennington, J., 101 S. Indiana av., Atl. City (1)
Pentel, Louis S., 307 16th st.. W. New York (9)
Peretzmann, J., 920 Hudson st., Hoboken (9)
Perham, Bertram S., 199 Lorraine av., Up.M'tcl'r(7)
Perham, Roy G., Hasbrouck Heights (2)
Perlberg, H. J., 921 Bergen av., Jersey City (9)
Pernetti, A. M., 338 6th av., Paterson (16)
Perkel, Louis L., 3263 Boulevard, Jersey City (9)
Perkins, J. L., 16 Alden st., Cranford (20)
Perry, Frank L., Woodstown (17)
Pessel, J. F., 224 W. State st., Trenton (11)
Peters, Chas. M., 921 Bergen av., Jersey City (9)
Peters, E. A. P., 394 Bergen av., Jersey City (9)
Peters, Richard C., 923 Park av., Plainfield (20)
Peterson, C. A., 921 Washington st., Hoboken (9)
Pettit, Herschel, Ocean City (5)
Petry, William, 109 Treacy av., Newark (7)
Phelan, Edward D., 18 South st., Newark (7)
Phelan, W. F., 124 Chilton st., Elizabeth (20)
Phelps, J. E., 203 Park av., Paterson (16)
Philhower, Geo. B., 281 Grant av., Nutley (7)
Phillips, A., 68 W. Market st., Newark (7)
Phillips, Claude B., 891 Haddon av., Collin'w'd (4)
Phillips, R. H. C., 144 W. State st., Trenton (11)
Phillips, Walter, Englewood (2)
Pierson, Carl L., 178 W. State st., Trenton (11)
Pierson, J. R., 224 W. State st., Trenton (11)
Pierson, Theodore A., Hopewell (11)
Pigott, Albert W., Skillman (17)
Pike, Charles E., 411 Newton st., Oaklyn (4)
Pilch, Arthur C., 1 Willard av., Bloomfield (7)
Piller, J., 245 Broadway, Passaic (16)
Pinckney, Frank H., Morristown (14)
Pindar, F. S., 960 Park av., N. Bergen (9)
Pindar, W. A., 975 Broadway, Woodcliff (9)
Pinkerton, W. Alfred, 854 Ave. C, Bayonne (9)
Pinneo, F. W., 439 Mt. Prospect av., Newark (7)
Pinsky, Meyer M., 944 S. 5th st., Camden (4)
Piskorski, A. V., 604 Jersey av., Jersey City (9)
Pitkin, George P., Bergenfield (2)
Pizzi, Francis W., 205 Park av., Orange (7)
Plant, J. S., 467 High st., Newark (7)
Plante, Amos A., 228 Dunnell rd., Maplewood (7)
Platt, Thomas H., 208 Dunellen av., Dunellen (12)
Plavin, Nathan J., 5407 Hud. Blvd., N. Bergen (9)
Plume, Clarence A., Succasunna (14)
Podell, Alfred, 69 W. Front st., Red Bank (13)
Pogoloff, Samuel H., Manville (18)
Poland, Geo. A , 25 E. Wash. av., Pleasantville (1)
Poland, Joseph, 1904 Pacific av., Atlantic City (1)
Polevski, J., 682 High st., Newark (7)
Pollak, Berth S., Laurel Hill, Secaucus (9)
Polizzotti, J. L., 193 Park av., Paterson (16)
Polow, Benjamin, 318 Hawthorne av., Newark (7)
Povalski, Alex W., 1925 Blvd , Jersey City (9)
Pomeranz, R., 31 Lincoln Park, Newark (7)
Pontery, Herb't, 89 Bowers st., Jersey City (9)
Pons, C. A., 501 Grand av., Asbury Park (13)
Pooley, Thomas R., Jr., Newton (19)
Potter, Benj. P., Hud. Co. Tub. San., Secaucus (9)
Potter, Ellen C., Glen Cairn Arms, Trenton (11)
Potter, R. T., 86 Harrison st., East Orange (7)
Potter, Robert C., 25 Fulton st., Newark (7)
*Powell, Wm. R., 702 Market st., Camden (4)
Powis, Ethel M., 198 W. State st., Trenton (11)
Prager, Bert A., Chatham (14)
Prather, J. W., Dumont (2)
Pratt, William H., 516 Cooper st., Camden (4)
Preston, Perry B., 12 Palm st., Newark (7)
Pregnall, James P., 501 Grand av., Asb. Park (13)
Price, Nathaniel G., 31 Lincoln Park, Newark (7)
Principato, Roberto, 402 Walnut st., Camden (4)
Pringle, F. A., 192 Claremont av., Montclair (7)
Prigger, E. R., Pennsgrove (17)
Proctor, Francis E., 1245 Gr'nw'd av., Trenton (11)
Proctor, James Wm., Englewood (2)
Proctor, Jesse, 15 N. 13th st., Newark (7)
Protzman, T. B., Englewood (2)
Prout, Charles, 414 6th av., Asbury Park (13)
Prout, Wm. B., West Englewood (2)
Prout, Thomas P., 19 Prospect st., Summit (20)
Pudney, W. R., 11 Seymour st., Montclair (7)
Pullen, G. F., Leonia (2)
Purcell, E. F., 800 Stuyvesant av., Trenton (11)
Pursell, William Dana, Phillipsburg (21)
Purdy, Chas. H., 35 Highland av., Jersey City (9)
Pyle, Louis A., 89 Fairview av., Jersey City (9)
Pyle, Immanuel, 51 Monticello av., Jersey City (9)
Pyle, Wallace, 15 Exchange pl., Jersey City (9)
*Pyle, William L., 678 Bergen av., Jersey City (9)

ASSOCIATE MEMBERS

Patti, F. A., 304 Broad av., Leonia (2)
Pavia, John R., 158 Hunterdon st., Newark (7)
Perham, Bertram S., 199 Loraine av., Up. M'tcl'r(7)
Peterson, Walter R., 224 W. State st., Trenton (11)
Piltz, Geo. Frank, 153 25th st., Guttenberg, N.J.(9)
Plain, I. H., 2 Stratford pl., Newark (7)
Poyas, Morton L., 1871 Pennington rd., Trenton(11)

Quigley, Frederick J., 4622 Boulevard, Union C'y (9)
Quinby, W. O'Gorman, 14 James st., Newark (7)
Quinn, John J., 152 Harrison av., Jersey City (9)
Quinn, Norman J., 3303 Pac. av., Atlantic City (1)
Quinn, S. T., 1143 E. Jersey st., Elizabeth (20)

Radding, M. B., 321 Elmora av., Elizabeth (20)
Rado, William, 190 Clinton av., Newark (7)
Rados, Andrew, 299 Clinton av., Newark (7)
Ragany, Joseph, 966 S. Broad st., Trenton (11)
Ragoff, George, 291 Osborne ter., Newark (7)
Rainey, W. G., 20 Nassau st., Princeton (11)
Ramos, Nicholas J., 188 Market st., Newark (7)
Ramsey, F. Muriel, Millville (6)
Ramsey, M. E., 435 E. Broad st., Westfield (20)
Randall, Chas. H., 50 Third av., Newark (7)
Randolph, John M., 131 Main st., Rahway (20)
Ranson, Bris. B., 601 Ridgew'd av., Maplewood (7)
Rathbone, T. H., 129 Summit av., Summit (20)
Rathgeber, C. F., 18 William st., E. Orange (7)
Rathgeber, Wm. M., 249 Roseville av., Newark (7)
Raughley, William C., Taunton av., Berlin (4)
Rauschenbach, P. E., 223 Broadway, Paterson (16)
Ravitz, S. F., 1113 Broad st., Newark (7)
Rawitz, Sidney B., 31 Lincoln Park, Newark (7)
Rayne, J. Edw., 116 Cherry st., Elizabeth (20)
Read, Jessie D., 166 Summit av., Jersey City (9)
Reading, Henry E., 538 E. 29th st., Paterson (16)
Reason, John J., Roosevelt (12)
Rector, Jos. M., 681 Bergen av., Jersey City (9)
*Reddan, M. W., 126 W. State st., Trenton (11)
Reed, F. Grendon, 52 Hill st., Morristown (14)
Reeves, E., 195 Lexington av., Passaic (16)
Reeves, J. Franklin, Bridgeton (6)

Reich, A. L., 83 Lyons av., Newark (7)
Reich, Jerome J., 1420 Maple av., Hillside (20)
Reich, S. B., Oradell (2)
Reid, Erwin W., Garfield (2)
Reilly, John V., 472 Sanford av., Newark (7)
Reiner, Jacob, 811 N. Broad st., Elizabeth (20)
Reinfeld, A. G., 354 Clinton av., Newark (7)
Reingold, Alex., 221 Garden st., Hoboken (9)
Reissman, E., 31 Lincoln Park, Newark (7)
Reitnauer, John S., 518 44th st., Union City (9)
Reitter, G. S., 144 Harrison av., E. Orange (7)
Remer, Daniel F., Mount Holly (3)
Renner, Dan Smith, Skillman (18)
Renzuli, Francesco, 228 S. 7th st., Newark (7)
RePass, Paul E., 42 Washington st., E. Orange (7)
Rettig, I. L., 36 Milford av., Newark (7)
Reynolds, Earle C., 657 Main av., Passaic (16)
Reynolds, Harry C., 657 Main av., Passaic (16)
Reynolds, G. G., 64 W. Main st., Freehold (13)
Rhoads, S. Creadick, Westville (8)
Rhone, David S., 1202 Haddon av., Camden (4)
Ribbans, Robert C., 63 Central av., Newark (7)
Rice, Franklin W., 184 South st., Morristown (14)
Rich, Charles, 191 Littleton av., Newark (7)
Rich, Harry H., 32 Broad st., Newark (7)
Richardson, A., 60 Orange rd., Montclair (7)
Richardson, Charles A., Closter (2)
Richardson, Emma M., 557 Stevens st., Camden(4)
Richardson, Jas. J., Hotel Claridge, Atlantic City (1)
Richie, E. W., Hackensack (2)
Ricketts, Henry E., 31 Lincoln Park, Newark (7)
Rieck, Walt. R., 379 Kearny av., Kearny (9)
Rieman, Aloysius, 3566 Boulevard, Jersey City (9)
Rigg, S. B., 506 Ridgewood av., Glen Ridge (7)
Riggins, Edwin N., 161 N. Arlington av., E. Or. (7)
Ripley, Charles D., 11 Lincoln Park, Newark (15)
Ripley, Edward W., 7 Trinity pl., Montclair (7)
Ripps, Maurice L., 331 Elmora av., Elizabeth (20)
Ristine, Edwin R., Westville (8)
Rizzolo, Edward M., 250 Mt. Prosp. av., Newark (7)
Robbin, Lewis, 18 Clinton pl., Newark (7)
Robbins, Charles M., 31 Lincoln Park, Newark (7)
Robbins, Eugene, 909 Broad st., Newark (7)
Robbins, Henry B., 144 Mercer st., Jersey City (9)
Robbins, Warren, Cape May City (5)
Roberts, D. C., 55 Randolph pl., S. Orange (7)
Roberts, Joseph E., Jr., 403 Cooper st., Camden (4)
Roberts, W. A., 9 Forest av., Caldwell (7)
Robertson, Grace M., 820 2d pl., Plainfield (20)
Robie, T. R., 144 Harrison st., E. Orange (7)
Robins, David, 94 Hawthorne av., Newark (7)
Robinson, J. T., Bound Brook (18)
Robinson, L. H., 31 Lincoln Park, Newark (7)
Robinson, Moe, 1014 E. Grand st., Elizabeth (20)
Rodman, E. Warren, Beverly (3)
Roeber, William J., 21 Nesbit pl., Irvington (7)
Roemer, Jacob, 213 Broadway, Paterson (16)
Rogers, Alvin S., 126 N. Warren, Trenton (11)
Rogers, Dorothy, Woodbury (8)
Rogers, Edwin B., 814 Haddon, Collingswood (4)
Rogers, Harry, 144 Harrison st., E. Orange (7)
Rogers, Harry L., Riverton (3)
Rogers, L. H., Municipal Colony, Trenton (11)
Rogers, Richard M. W., 1 Wallace st., Newark (7)
Rogers, Robert H., 49 Ninth av., Newark (7)
Rogers, W. N., 1255 Brunswick av., Trenton (11)
Rona, Maurice, 159 Bayard st., N. Brunswick (12)
Rosecrans, J. H., 826 Hudson st., Hoboken (9)
Rosenberg, Albert B., 1921 Boulevard, Jer. City (9)
Rosenberg, J., 692 Bergen av., Jersey City (9)
Rosenberg, L. Charles, 11 Murray st., Newark (7)
Rosenblatt, S., 1920 Pacific av., Atlantic City (1)
Rosenstein, Jacob, 568 Bergen av., Jersey City (9)
Rosenstein, Samuel L., 557 Clinton av., Newark (7)
Rosenthal, A., Atlantic Highlands (13)
Ross, Alex. S., 542 Cooper st., Camden (4)
Roth, Oswald H., 210 Littleton av., Newark (7)
Rothschild, K., 49 Bayard st., New Brunswick (12)
Rothenberg, Samuel, 1 Hillside av., Newark (7)
Rothhouse, Burnet, 19 Lincoln Park, Newark (7)
Rothseid, Abraham, 29 Scheerer av., Newark (7)
Rowan, Henry M., 224 W. State st., Trenton (11)
Rowe, Norman L., 828 Grand st., Jersey City (9)
Rowe, J. A., Ridgefield (2)
Rowland, J. H., 159 New st., N. Brunswick (12)
Rowland, James J., Highlands (13)
Roy, Bert W., Sussex (19)
Roy, Jos. N., 95 17th av., Paterson (16)
Rube, J. H., Ridgewood (2)
Rubin, A. David, 401 1st av., Asbury Park (13)
Rubin, Henry S., Morristown (14)
Rubin, A. A., 379 Washington av., Belleville (7)
Rubinow, Saul M., 755 High st., Newark (7)
Ruch, Louis, Englewood (2)
Ruch, Valentine, Englewood (2)
Rufe, John J., High Bridge (10)
Rumage. Wm. T., 44 Walnut st., Newark (7)
Rundlett, Emelia V., 79 Prosp. st., Jersey City (9)
Runnells, J. E., Bonnie Burns San.,ScotchPlains(20)
Runyan, Wm. J., 106 Broad st., Bloomfield (7)
Runyon, L. P., 82 Somerset st., N. Brunswick (12)
Ruoff, Andrew C., 494 New York av., Union City (9)
Russell, David L., 690 Bergen av., Jersey City (9)
Russell, Edward W., 801 Cooper st., Camden (4)
Russell, L. C., 192 Clinton av., Newark (7)
Ruttenberg, Max, 210 State st., Camden (4)
Ruvane, J. J., 38 Bentley av., Jersey City (9)
Ryan, John N., 158 Lexington av., Passaic (16)
Ryley, H. W., East Rutherford (2)

Associate Members

Rineberg, Irving E., New Brunswick (12)
Roberts, A. H., 24 S. 9th st., Newark (7)
Rucker, William C., Hack'ns'k Hosp., Hack'n's'k (2)
Russomanno, R. L., 181 Clinton av., Newark (7)

Sacco, Anthony, 440 New York av., Union City (9)
Sachs, Fred, 177 Bergen av., Jersey City (9)
Sachs, Wilbert, 921 Bergen av., Jersey City (9)
Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
Salasin, Samuel L., 511 Pacific av., Atlantic City (1)
Salmon, Edw. H., 669 Bergen av., Jersey City (9)
Salsberg, Ralph H., 325 Peshine av., Newark (7)
Salvati, Leo H., 224 Walnut st., Westfield (20)
Salzman, Nathan, 306 Broadway, Paterson (16)
Sandella, J. F., 169 New st., New Brunswick (12)
Sandler, M., Fort Lee (2)
Sanfacon, Thomas A., 82 Ward st., Paterson (16)
Santangelo, Stephen, 304 Varick st., Jer. City (9)
Santosky, Benj. B., 162 Bergen av., Jersey City (9)
Saradarian, A. V., 481 New York av., Union City(9)
Sarla, Michael, Hackensack (2)
Saslow, Benjamin, 680 Clinton av., Newark (7)
Satchwell, H. H., 640 Stuyvesant av., Irvington (7)
Saunders, O. W., 1700 Broadway, Camden (4)
Sawyer, Blackwell, Lakewood (15)
Sawyer, E. E., Hackensack (2)
Sayre, Wm. D., 69 Maple av., Red Bank (13)
Sbarra, F., 233 Sixth av., Newark (7)
Scammell, F. G., 40 S. Clinton av., Trenton (11)
Scanlan, David W., 15 S. Ill. av., Atlantic City (1)
Schaaf, Edward O., 217 S. Orange av., Newark (7)
Schaaf, Royal A., 413 Mt. Prospect av., Newark (7)
Schaefer, E. P., 12 Harrison pl., Irvington (7)
Schaffer, Nathan, 94 S. Munn av., E. Orange (7)
Schall, Elmer R., 7th & Elm sts., Camden (4)
Schauffler, W. G., 21 Morven pl., Princeton (11)
Schapiro, Jos., 712 Palisade av., Union City (9)
Schectman, Vera, 385 Osborne ter., Newark (7)
Scheffler, W. A. H., 511 Cooper st., Camden (4)
Schellenger, E. A. Y., 429 Cooper st., Camden (4)
Schenk, Jos. R., 318 W. 7th st., Plainfield (20)
Schenker, B. N., 246 5th st., Jersey City (9)
Schept, S. S., 528 37th av., Union City (9)

Scher, Maurice A., 141 Lyons av., Newark (7)
Schildkraut, J. M., 170 W. State st., Trenton (11)
Schiller, Nicholas, 9 Pierce st., Newark (7)
Schilling, A. B., 727 Jefferson av., Elizabeth (20)
Schimelfenning, R. D., 258 Clarem't av., M'tcl'r (7)
Schisler, Milton M., Florence (3)
Schlein, August, 707 Park av., Hoboken (9)
Schlichter, C. H., 556 N. Broad st., Elizabeth (20)
Schmidt, Hilmar R., Lincoln Park (14)
Schmidt, Walter W., Cliffside Park (2)
Schmitz, Mathias, Denville (14)
Schneckendorf, S., 203 Harrison av., Jersey City (9)
Schneider, C. A., 694 Clinton av., Newark (7)
Schneider, Louis, 874 S. 13th st., Newark (7)
Schneider, Louis A., 412 17th st., West N. Y. (9)
Schrack, Helen F., 216 N. 5th st., Camden (4)
Schramm, Joseph A., 23 Darcy st., Newark (7)
Schreck, Harry, 139 Roseville av., Newark (7)
Schroeder, H. J. L., 202 W. State st., Trenton (11)
Schruggs, Wm. J., 3005 Kearsage rd., Camden (4)
Schulman, A. S., 4638 Hudson blvd., Union City(9)
Schuehner, Wm. F., 264 First st., Jersey City (9)
Schulman, Robert, Mendem rd., Morristown (14)
Schulsinger, S., 48 Walnut st., Newark (7)
Schulte, H. A., 701 Clinton av., Newark (7)
Schultz, A. M., 379 Union av., Paterson (16)
Schuck, Traugott E., 58 9th st., Hoboken (9)
Schurman, E. W., 710 Ocean av., Jersey City (9)
Schwartz, Henry C., Atco, N. J. (4)
Schwartz, Samuel H., 414 Park av., Plainfield (20)
Schwarz, R. T. D., 2801 Hudson Blvd., Jer. City (9)
*Schwarz, Emanuel, 561 High st., Newark (7)
Schwarz, Henry J., 5560 Hudson Blvd., N. Berg'n(9)
Schwarz, W. J. A., 269 Cator av., Jersey City (9)
Schwarzkopf, Geo. 2900 Pacific av., Atlantic City (1)
Sciorsci, Edward P., 609 Bloomfield st., Hoboken(9)
Scott, F., Franklin (19)
Scott, E. A., Belle Mead San., Belle Mead (13)
Scott, Fred W., 103 Bayard st., New Brunswick (12)
Scott, Harold R., Morristown (14)
Scott, Karl M., 1616 Pac. av., Atlantic City (1)
Scott, Parry M., Beverly (3)
Scott, R. Hunter, 205 Roseville av., Newark (7)
Scott, Samuel G., 141 Bergen av., Jersey City (9)
Scranton, Chas. W., 31 Washington st., E. Or. (7)
Scribner, Charles H., Hamberg Tyke, Paterson (16)
Scruggs, Wm. J., 3005 K'rs'ge rd., Fairv'w,Cam.(4)
Scudder, F. D., 63 S. Fullerton av., Montclair (7)
Seullion, Arthur, Cliffside (2)
Sealey, H. J., Dumont (2)
Seely, Roy, 78 N. Clinton st., Trenton (11)
Seidler, William F., 29 Rossmore pl., Belleville (7)
Seidler, V. B., 16 Plymouth st., Montclair (7)
Seidman, E. A., 580 High st., Newark (7)
Seidman, Marcus, 580 High st., Newark (7)
Seifert, Edwin A., 247 Claremont av., Montclair (7)
Seiler, B., Cliffside Park (2)
Seitzick, Hannah E., 733 Hamilton av., Trenton (11)
Sekerak, Albert J., 977 S. Broad st., Trenton (11)
Selinger, Samuel, 413 16th st., W. New York (9)
Sell, Frederick W., 113 Commerce st., Rahway (20)
Sellers, Robt. R., 19 Chestnut st., Newark (7)
Sena, Marie A., 5674 Boulevard, N. Bergen (9)
Sender, Fannie, 191 Whitehead st., South River (12)
Senseman, Theo., 3600 Pac. av., Atlantic City (1)
Sesta, Joseph, 282 Fulton av., Jersey City (9)
Sewall, Millard F., Bridgeton (6)
Seward, Fred H., 40 Green Vill'ge rd., Madison (14)
Seward, Wm. H., Madison (14)
Sexsmith, George H., 719 Ave. C, Bayonne (9)
Seybold, Arthur D., 302 E. 7th st., Plainfield (20)
Seymour, Geo. A., 253 Orchard st., Elizabeth (20)
Seymour, E. T., Tenafly (2)
Sferra, Alfred F. W., Bound Brook (18)
Shafer, Alfred H., 405 Cooper st., Camden (4)
Shafer, Fred W., 634 Penn. av., Camden (4)
Shangle, Milt A., 34 Prince st., Elizabeth (20)
Shannon, J. B., 56 Church st, Montclair (7)
Shannon, Lardner M., 66 S. Fullerton av., M'tcl'r(7)
Shapiro, Louis, 242 Broad st., Newark (7)
Shapiro, L., 375 Broadway, Paterson (16)
Shapiro, Maurice, 750 Ave. C, Bayonne (9)
Shapiro, Nathan, 192 Palisade av., Union City (9)
Sharp, Charles E., Port Morris (6)
Sharp, Jennie M., 726 Cooper st., Camden (4)
Sharp, R. L., 726 Cooper st., Camden (4)
Saul, F. G., 10 Washington st., Bloomfield (7)
Shaw, Ernest B., 811 Collings av., Collingswood (4)
Shaw, Joseph B., 119 S. Warren st., Trenton (11)
Sheeran, V. J., 269 Jewett av., Jersey City (9)
Sheets, C. C., Paulsboro (8)
Shenfeld, Isaac, 501 Pacific av., Atlantic City (1)
Shepperd, Frank R., Millville (6)
Sherk, A., Lincoln, 2647 Westfield av., Camden (4)
Sherlock, Margaret E., Vineland State School (18)
Sherman, Alton L., 26 Northfield av., W. Orange (7)
Sherman, A. Russell, 671 Broad st., Newark (7)
Sherman, Byron G., Maple av., Morristown (14)
Sherman, Elbert S., 671 Broad st., Newark (7)
Sherman, Fuller G., Woodbury (8)
Sherman, W. E., Geo. & Schureman,N.Br'nsw'k(12)
Sherron, Clifford M., Salem (17)
Shill, Benjamin, 131 Renner av., Newark (7)
Shimer, A. Burton, 606 Pac. av., Atlantic City (1)
Shimer, Floyd A., Phillipsburg (21)
Shipman, Frank C., 3663 Boulevard, Jersey City (9)
Shipman, James S., 542 Cooper st., Camden (4)
Shippe, David N., Midvale (16)
Shipps, Hammel P., Delanco (3)
Shirrefs, R. A., 57 Broad st., Elizabeth (20)
Shivers, C. H. deT., 121 S. Ill. av., Atlantic City (1)
Shivers, Chas. H., 121 S. Ill. av., Atlantic City (1)
Shook, B. E., 284 Bergen av., Jersey City (9)
Shope, E. P., 956 Newton av., Camden (4)
Short, Francis J., 670 Jersey av., Jersey City (9)
Shull, E. C., 150 N. 32d st., Camden (4)
Shull, J. Virgil, 320 High st., Perth Amboy (12)
Shulman, Abraham, 528 E. 29th st., Paterson (16)
Shulman, N. L., 538 45th st., Union City (9)
Šica, Samuel, 431 E. State st., Trenton (11)
Siekel, E. M., Lakewood (15)
Sieber, Isaac G., 204 Merchant st., Audubon (4)
Siegel, A. E., 3831 Atlantic av., Atlantic City (1)
Siegel, J. W., 96 S. 10th st., Newark (7)
Siegler, Julius, 646 Bergen av., Jersey City (9)
Sieveke, J., 106 Lexington av., Passaic (16)
Silk, Chas. I., 189 Rector st., Perth Amboy (12)
Sill, John B., 1129 Hamilton av., Trenton (11)
Silver, E. Drew, Hightstown (11)
Silver, George A., Hightstown (11)
Silver, H. B., 190 Clinton av., Newark (7)
Silvers, Homer I., 16 S. Suffolk av., Ventnor (1)
Silverstein, Benj. J., 32 Hillside av., Newark (7)
Silverstein, J. M., 73 Main st., Millburn (7)
Simeone, Peter A., 555 38th st., Union City (9)
Simmons, Albert V., 720 Prospect st., Maplew'd (7)
Simms, Geo. F., 541 Page st., Lyndhurst (7)
Simon, Henry, 423 Elizabeth av., Elizabeth (20)
Simon, Ludwig, 201 Ferry st., Newark (7)
Simon, Morris L., 174 Washington pl., Passaic (16)
Simpkins, Ray, Bridgeton (6)
Sinclair, Donald B., Princeton (11)
Singer, Max, 147 Johnson av., Newark (7)
Sinexon, Harry L., Paulsboro (8)
Sinkinson, Chas. D., Jr., 1616 Pac. av., Atl. City (1)
Sinton, John Y., Imlaystown (11)
Sirken, Chas., 887 Summit av., Jersey City (9)
Sirott, Barnett H., 409 State st., Perth Amboy (12)
Sista, Charles R., 476 Hamilton av., Trenton (11)
Skinner, William F., Washington (21)
Skvarla, J. A., Wallington (2)
Skwirsky, Jos., 170 Hawthorne av., Newark (7)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slaff, F., 16 Grove st., Passaic (16)
Slavin, Paul, Glen Gardner ((10)
Sloan, Samuel L., 182 Belmont av., Paterson (16)

Slobodien, Benj. F., 107 Market st.,Perth Amboy(12)
Slocum, Harry B., Bath av., Long Branch (13)
Sly, John L., 382 Springfield av., Summit (20)
Small, E. Lester, Medford (3)
Smalley, Mahlon C., Peapack (18)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, E. W., 167 N. Grove st., E. Orange (7)
Smith, Alexander L., 267 Blvd., Jersey City (9)
Smith, A. L. M., 62 Bayard st., New Brunswick (12)
Smith, Andrew M., 344 Phila. av., Egg Harbor (1)
Smith, Byron J., 104 Parker av., Maplewood (7)
Smith, C. W., Passaic (16)
Smith, Charles B., Washington (21)
Smith, E. L., Soho Hospital, Belleville (7)
Smith, G. H., 534 Central av., East Orange (7)
Smith, Houghton, 1063 S. Clinton av., Trenton (11)
Smith, H. G., Cedar Grove (7)
Smith, Harold W., 179 Clinton av., Newark (7)
Smith, James D., 701 N. 6th st., Camden (4)
Smith, J. Vincent, 463 State st., Perth Amboy (12)
Smith, Leon A., 72 Grove st., Passaic (16)
Smith, L. H., 32 Washington st., E. Orange (7)
Smith, J. J., 325 13th av.. Newark (7)
Smith, T. A., Short Hills (7)
*Smith, Thomas J., Bridgeton (6)
Smith, Warren H., Newton (19)
*Smith, Walter H., 100 Kgs. Hwy., Haddonfield (4)
Smith, W. Henly, 34 W. State st., Trenton (11)
Snavely, Earl H., City Hosp., Newark (7)
Snedecor, S. T., 50 Anderson st., Hackensack (2)
Snyder, J. E. C., 1023 Garden st., Hoboken (9)
Sobin, Julius, 24 Waverly av., Newark (7)
Solk, Arthur S., 595 S. 13th st., Newark (7)
Somers, Fred L., 144 Harrison av., Orange (7)
Sommer, G. N. J., 120 W. State st., Trenton (11)
Sooy, L. T., Pitman (8)
Spalding, H. J., 512 45th st., Union City (9)
Spallone, Jos. C., 123 Mt. Prospect av., Newark (7)
Spano, Frank, 320 47th st., Union City (9)
Spath, George B., 722 Hudson st., Hoboken (9)
Spalding, H. J., 512 45th st., Union City (9)
Spence, H., 2540 Boulevard, Jersey City (9)
Spencer, Alvan, 19 E. Blackwell st., Dover (14)
Spencer, John H., Newton (19)
Spencer, Ira T., Main st., Woodbridge (12)
Spickers, William, 6 Church st., Paterson (16)
Spiegelglass, A. B., Hackensack (2)
Sprague, Edw. W., 86 Washingt'n st., Newark (7)
Sprague, Seth B., 301 York st., Jersey City (9)
Spurgeon, D. L., Newton (19)
Staehle, Richard H., 34 Lyons av., Newark (7)
Stahl, Alfred, 55 Lincoln Park, Newark (7)
Stahl, Charles, 659 Sanford av., Newark (7)
Stalberg, Samuel, 1109 Pac. av., Atlantic City (1)
Stamps, G. Ruffin, 214 E. Verona av., Plea'v'le (1)
Stanton, Nath. B., 734 Park av., Plainfield (20)
Stark, M., 557 Broadway, Paterson (16)
Staub, E. Milton, 531 E. Broad st., Westfield (20)
Steadman, E. T., 107 Christopher st., Montclair (9)
Stedman, H. E., Englewood (2)
Steele, Stephen, 500 Wood av., Linden (20)
Steele, William, Beesley's Point (5)
Stein, L. A., 205 Market st., Trenton (11)
Steffen, Charles T., Dunellen av., Dunellen (12)
Stein, Emil, 607 Park av., Elizabeth (20)
Stein, George H., Elizabeth (20)
Stein, Harry M., 227 W. Broadway, Paterson (16)
Stein, Isadore, 210 Elizabeth av., Elizabeth (20)
Stein, Jacob M., 68 Columbia ter., Weehawken (9)
Stein, Martin H., 163 2d st.. Elizabeth (20)
Steiner, Edwin, 19 Lincoln Park, Newark (7)
Stephenson, G. A., Jersey City Hosp., Jer. City (20)
Stern, Arthur, 224 E. Jersey st., Elizabeth (20)
Stern, Samuel, 2815 Pacific av., Atlantic City (1)
Stevens, J. Thompson, 55 Park st., Montclair (7)
Stevens, Merton H., 144 Harrison st., E. Orange (7)
Stevenson, Alex. M., 6622 Ventnor av., Atl City (1)
Stevenson, Geo. S., Hasbrouck Heights (2)
Steuart, David T., 6 Norwood ter., Summit (20)
Stewart, Irving J., Swedesboro (8)
Stewart, Walter B., 8 N. Tal'h's'e av., Atl. C'y (1)
Stewart, W. Blair, Pac. & N. Car. avs., Atl. City (1)
Stewart, Robt. G., 79 Midland av., Montclair (7)
Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
Stillwell, Aaron L., Somerville (18)
Stillwell, H. C., 70 Irving pl., Rahway (12)
Stinson, Richard, 641 E. 18th st., Paterson (16)
Stockfisch, Robt., 364 Boulevard, Jersey City (9)
Stoddard, Gordon V., 41 S. Munn av., E. Orange (7)
Stokes, Earl B., 49 Prospect st., E. Orange (7)
Stokes, Joseph, Moorestown (3)
Stokes, Samuel Emlen, Moorestown (3)
Stone, A. L., 2838 Berkley st., Comden (4)
Stone, R. G., State Hospital, Trenton (11)
Stout. Harry Wilson, Wenonah (8)
Stout, J. Phillip, 165 Jewett st., Jersey City (9)
Strahan, F. G., 473 Broadway, Long Branch (13)
Straub, H. H., 242 Springdale av., E. Orange (7)
Straughan, C. C., 23 Monmouth st., Red Bank (13)
Strauss, Arthur, 137 Pavil. av., Long Branch (13)
Street, D. B., 27 Woodlawn av., Jersey City (9)
Strelinger, Edward A., 414 Eliz. av., Elizabeth (20)
Strom, A., 410 W. 7th st., Plainfield (20)
Stuart, J. Earle, 552 Second av., Plainfield (20)
Stuart, W. C., 518 Hudson st., Hoboken (9)
Subin, Harry, 1616 Pac. av., Atlantic City (1)
Sullivan, Chas. J., 57 Paterson st., New Bruns. (12)
Sullivan, D. C., 22 Fairmount ter., Jersey City (9)
Sullivan, George F., 510 Hudson st., Hoboken (9)
Sullivan, James A., 668 Jer. av., Jersey City (9)
Sullivan, Margaret N., 70 Undercliffe rd., M'tcl'r (9)
Sulouff, S. Henry, 662 Newark av., Jersey City (9)
Summerill, Garnett, 330 Cooper st., Camden (4)
Summerill, John M., Pennsgrove (17)
Summers, A. D., 180 Nassau st., Princeton (11)
Summey, Thomas J., Moorestown (3)
Surnamer, Isaac, 345 Broadway, Paterson (16)
Suter, Harry F., Pennsgrove (17)
Sutherland, W. S., Mt. Holly (3)
Sutherland, W. W., 320 Broadway, Paterson (16)
Sutphen, E. Blair, 26 Maple av., Morristown (14)
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove (7)
Swan, Guy H., Beachwood (15)
Swain, Richard D., 211 Roseville av., Newark (7)
Sweeney, William J., 68 Clifton ter., Weehawken(9)
Swern, Nathan, 130 W. State st., Trenton (11)
Swift, Edw. M., 285 Smith st., Perth Amboy (12)
Swiney, Merrill A., 325 Ave. C, Bayonne (9)
Symes, Earl H., 161 Kearny av., Kearny (7)
Synnott, M. J., 63 S. Fullerton av., Montclair (7)
Szerlip, L., 31 Lincoln Park, Newark (7)
Szymanski, J., 618 Main av., Passaic (16)

Associate Members

Salway, Benj., 321 S. Broad st., Trenton (11)
Sax, Max T., 84 Grove st., Bloomfield (7)
Scassera, B. B., 110 Nassau st., Trenton (11)
Scielzo, M. F., 777 Madison av., Paterson (16)
Sheehan, Daniel C., 773 Sanford av., Newark (7)
Stage, Earl, 601 Clinton av., Newark (7)
Stasiva, Stanley J., 11 E. 25th st., Bayonne (9)
Stoddard, Gordon V., 41 S. Munn av., E. Orange (7)

Taber, F. H., 3 Elm Row, New Brunswick (12)
Taber, L., 266 Van Houten st., Paterson (16)
Talbot, Herbert S., 144 Harrison st., E. Orange (7)
Tannert, C. H., 331 33rd st., Woodcliffe (9)
Tarbell, Harold A., 11 Pennington st., Newark (7)
Tataryan, H., 422 New York av., Union City (9)
Taylor, Edward, Franklin (19)
Taylor, H. W., Englewood (2)
Taylor, Walt. A., 450 Rutherford av., Trenton (11)
Teeter, Charles E., 418 Orange st., Newark (7)
Teeter, John N., Englewood (2)
Teimer, Theodore, 17 Hillside av., Newark (7)

Teller, D. W., Morristown (14)
Tellman, D. H., 120 Lexington av., Passaic (16)
Temes, J. Howard, 293 Ege av., Jersey City (9)
Temple, Arthur H., 164 Jefferson, Passaic (16)
Ten Eyck, John D., Franklin Park (18)
Tennis, E. N., Tenafly (2)
Terhune, P. H., 171 Paulson av., Passaic (16)
Teriberry, W. K., 15 Washington st., Newark (7)
*Terk, A. P., 295 Connant st., New York, N.Y. (9)
Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
Tether, Russel K., Cloister (2)
Thalheimer, E. J., Vineland (6)
Thomas, Floyd A., Flemington (10)
Thomas, George N., Vineland (6)
Thomas, J. H., Jr., 270 Lenox av., S. Orange (7)
Thomas, Ralph B., 793 Montg'ry st., Jer. City (9)
Thomas, Mary Louise, 1 Euclid av., Elizabeth (20)
Thomas, Thomas S., 135 South st., Morristown (14)
Thompson, Arthur F., 157 Harrison st., E. Or. (7)
Thompson, Austin B., 479 Highland av., Orange (7)
Thompson, C. S., Fair Oakes Sanit'r'm, Summit (7)
*Thompson, David C., 98 Broad st., Bloomfield (7)
*Thompson, R. J., 128 E. Grant av., Roselle P'k(20)
Thomson, T. F., Lakewood (15)
Thorne, Nathan, Moorestown (3)
Thorne, Wm. P., 30 Main st., Butler (16)
Thum, Ernest, 819 Ave. C, Bayonne (9)
Tidaback, J. D., 447 Springfield av., Summit (20)
Tidwell, G. W., 17 Union Blvd., Wallington (2)
Tidwell, H. F., 229 16th st., W. New York (9)
Tildon, John W., 54 N. Clinton st., E. Orange (7)
Timberlake, B. H., 1616 Pac. av., Atlantic City (1)
Timlin, James W., 64 Beech st., Arlington (9)
Tirrell, C. M., 36 Spruce st., Newark (7)
Titman, Russell E., 275 Dodge st., E. Orange (7)
Toal, Joseph, Ridgefield (2)
Tobey, F. J., 11 Hazelwood av., Newark (7)
Tobin, Adolph, Lakewood (15)
Todd, Francis H., 83 Auburn st., Paterson (16)
Tomassi, Chas. F., 173 Lafayette st., Newark (7)
Tomec, Richard F., 55 S. Park st., Montclair (7)
Tomlin, H. Hulburt, Wildwood (5)
Tompkins, Grenelle B., Flemington (10)
Tompkins, William, Hohokus (16)
Topkins, Isidor I., Califon (10)
Townsend, I., 39 W. State st., Trenton (11)
Townsend, John, Ocean City (5)
Townsend, T. E., Westwood (2)
Toy, Calvert R., 92 Bayard st., New Brunswick (12)
Toye, John E., 590 Kearny av., Arlington (7)
Tracy, George T., Beverly (3)
Trainor, James H., 40 Johnson av., Newark (7)
*Traub, Paul, 200 Spring st., Trenton (11)
Traverso, Daniel, Belmar (13)
Treiber, Benj. A., 626 Perry st., Trenton (11)
Trippe, C. M., 793 Asbury av., Asbury Park (13)
Trossbach, Herman, Bogota (2)
Truax, Alfred J., Boonton (14)
Tuers, George E., 418 Park av., Paterson (16)
Turi, A. E., 57 Garside st., Newark (7)
Tutchulte, E., 111 Mt. Pleasant av., Newark (7)
Turner, C. F., Grove & Cambr. sts., Montclair (7)
Turner, I. F. P., 244 W. State st., Trenton (11)
Turner, Wm. F., 519 Magie st., Elizabeth (20)
Tweddel, Geo. K., 156 Paterson st., Paterson (16)
Twitchell, A. B., 162 S. Orange av., S. Orange (7)
Tymeson, Walt. R., 310 Main st., Orange (7)
Tyndall, H. H., 83 Highwood ter., Weehawken (9)
Tyrrell, Geo. W., 380 State st., Perth Amboy (12)
Tyson, Francis B., Leonia (2)

Associate Member

Tomainoli, Michele, 2 Fulton st., Weehawken (9)

Ulan, Oscar, 174 Fleming av., Newark (7)
Ulmer, Chester I., Gibbstown (8)
Ulmer, David H. B., Moorestown (3)
Underwood, J. Harris, Woodbury (8)
Upham, Helen T., 305 3d av., Asbury Park (13)
Uptigrove, E. P., Vernon (19)
Urbanski, Adrian X., 148 Market st., P. Amboy(12)
Urbanski, Mat. F., 314 Wash st., Perth Amboy (12)
Urevitz, A., 495 New York av., Union City (9)
Uzzell, Edw. F., 2703 Pacific av., Atlantic City (1)

Vaczi, Stephen, 983 So. Broad st., Trenton (11)
Vail, Herbert B., 301 Washington av., Belleville (7)
Vail, James Lindley, 24 Holly st., Cranford (20)
Vail, William Penn, Blairstown (21)
Vannatta, Geo. W., 224 N. Park st., E. Orange (7)
Vanneman, Joseph S., 180 Nassau st., Princ't'n(11)
Van Deusen, Edwin H., Vineland (6)
Van Dyke, Joseph S., Palisade Park (2)
Van Dyke, Benjamin S., Cranbury (12)
Vanderhoff, I. M., 9 Clinton st., Newark (7)
Vandersluis, H., Park Ridge (2)
Van Deer Veer, H. G., 295 Montg'ry, Bl'mf'ld (7)
Van Emburg, G. H., 575 Belgrove dr., Arlington (7)
Van Erde, A. H., 339 Lafayette av., Hawthorne (16)
Van Geison, Edward J., 17 Park pl., Bloomfield (7)
Van Horn, A. F., 514 Central av., Plainfield (20)
Vanderbeek, And'w B., 174 Broadway, Paterson (16)
Vanderbeek, S. W., Englewood (2)
Van Ness, H. R., 218 Mt. Prospect av., Newark (7)
Van Neste, George V., Hopewell (11)
Van Schott, Gerald J., 254 L'v'gt'n av., Passaic (16)
Van Sciver, John E. L., 106 B'way, Camden (4)
Van Urk, F. T., 149 Lexington av., Passaic (16)
Van Winkle, J. S., 297 Broadway, Paetrson (16)
Varney, W. H., Washington (21)
Varriano, John L., 3258 Blvd., Jersey City (9)
Verbeck, Geo. B., 26 Washburn pl., Caldwell (4)
Vilapiano, Jos. G., 710 Mattison av., Asbury P'k (13)
Vinciguerra, Michael, 410 Westm'ster av., Eliz. (20)
Visconti, Jos. A., 711 Garden st., Hoboken (9)
Vita, F. T., Grantwood (2)
Vitale, Dominick, 646 Palisade av., W. New York(9)
Viteri, Louis, Mt. Holly (3)
Vogel, H. A., 1016 E. Jersey st., Elizabeth (20)
Von Deeston, H. T., 268 Palisade av., Jersey C'y(9)
Von Hofe, F. H., 255 Conway ct., E. Orange (7)
Voorhees, Lamar, Newton (19)
Voorhees, Florence E., 83 Lincoln Park, Newark(7)
Voorhees, H. C., 43 Bayard st., New Brunsw'k (12)
Voorhies, William S. Mendham (14)
Vosburg, Fred, 61 Passaic av., Passaic (16)
Vostrosablin, N. A., 121 Grand st., Jersey City (9)
Vroom, W. L., Ridgewood (2)
Vreeland, Hamilton, 232 S. Irving, Ridgewood (9)
Vreeland, Ralph J., 266 Van Houten st., Pat'son (16)
Vreeland, R. D., 333 Lyons av., Newark (7)
Vreeland, Wm. N., 32 Bergen av., Jersey City (9)

Associate Members

Van Duzer, Reeves B., 304 Park av., U. M'tcl'r (7)
Van Winkle, Chas. I., 192 Home av., Rutherford (2)
Vorhees, E. R., M.D.C., Somerville (18)

Wade, S. F., 555 Newark av., Elizabeth (20)
Wagner, Otto, 111 Stiles av., Elizabeth (20)
Wagner, J. G., Riverside (3)
Wainwright, F. P., Bridgeton (6)
*Waite, George H., High st., Newark (7)
Wakeley, W. E., 521 Main st., E. Orange (7)
Wakeley, William A., 120 Main st., Orange (7)
Walker, Ada Harris, Vineland (6)
Walker, H. Burton, Vineland (6)
Walker, Harold G., Everett av., Wyckoff (16)
Walker, Levi M., 151 S. Penna. av., Atl. City (1)
Walker, R. B., 108 Church st., New Brunswick (12)
Wallach, B. N., Plainfield (18)
Wallhauser, H. J. F., 31 Lincoln Park, Newark (7)
Walsh, T. M., Hasbrouck Heights (2)
Walsh, Thos. J., 335 S. Broad st., Elizabeth (20)
Walsh, Thomas J., 1158 E. State st., Trenton (11)
Walton, Gordon G., 17 Church st., Paterson (16)
Walton, R. W., 48 N. Fullerton av., Montclair (7)

Wambaganss, M., 44 Devine st., Newark (7)
Wantoch, Joseph, Cartaret (12)
Ward, Albert J., 71 Washington av., Morrist'n (14)
Ward, Alfred W., Demarest (2)
Ward, G. Harold, Englewood (2)
Ward, Gertrude P., 41 Park pl., Bloomfield (7)
Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
Ward, Lettie A., 325 Cooper st., Camden (4)
Ward, Wm. R., 112 Chancellor av., Newark (7)
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THE JOURNAL

OF THE

Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 6 Orange, N. J., June, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

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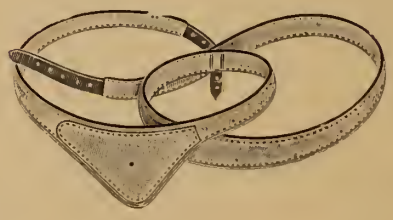
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IMPERTURBABILITY

In the physician or surgeon no quality takes rank with imperturbability, and I propose for a few minutes to direct your attention to this essential bodily virtue. Perhaps I may be able to give those of you in whom it has not developed during the critical scenes of the past month a hint or two of its importance, possibly a suggestion for its attainment. Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness, or, to use an old and expressive word, phlegm. It is the quality which is most appreciated by the laity though often misunderstood by them; and the physician who has the misfortune to be without it, who betrays indecision and worry, and who shows that he is flustered and flurried in ordinary emergencies, loses rapidly the confidence of his patients. In full development, as we see it in some of our older colleagues, it has the nature of a divine gift, a blessing to the possessor, a comfort to all who come in contact with him.—Osler, William: Aequanimitas, Philadelphia, P. Blakiston's Son & Co., 1904, p. 3.



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DR. J. ALLEN PATTON TO RETIRE

Newark, N. J., May 20—Dr. J. Allen Patton, Medical Director and Second Vice-President of the Prudential Insurance Company of America, will retire from active duty with that organization on July 1, next, after 38 years of service.

Business associates and other friends of the executive attended a farewell dinner in his honor at the Hotel Suburban, East Orange, N. J., last night and he plans to leave for his new home in California on or about Friday, May 26.

Dr. Joseph E. Pollard, Associate Medical Director, was Toastmaster at last night's banquet, while other speakers were John K. Gore, Vice-President and Actuary, and Dr. L. F. MacKenzie, also Associate Medical Director.

Dr. MacKenzie, in behalf of the Medical Department, presented the guest of honor with a set of golf clubs.

Dr. Patton's achievements as chief executive of the Medical Department of the Prudential have been numerous. Under his guidance the Home Office Infirmary has been developed from a small unit into a modern, well-equipped hospital. In 1932 alone 59,000 treatments were given to home office employees.

The Laboratory and Longevity Service has been so improved in equipment and scope that in 1932 there were 118,491 specimens examined in the laboratory, an average of more than 394 for each working day.

Dr. Patton is the son of a prominent physician, Dr. William R. Patton, of Charleston, Ill. There he was born and received his early education. After this he entered the University of Illinois and graduate with the degrees of B. S. in 1888, following which he went to Rush Medical College, Chicago, and 2 years later obtained his degree of doctor of medicine.

He began his Prudential career on May 3, 1895, as an examiner in Chicago, and became a member of the Home Office Medical Staff on May 18, 1908. In January, 1909, he was made Assistant Medical Director; in January, 1913, he was promoted to the rank of Associate Medical Director, and in January, 1920, was placed in charge of the department as Medical Director. On January 13, 1930, he was again promoted, this time to the rank of Second Vice-President and Medical Director.

Since he came to the Home Office, Dr. Patton has been an outstading member of the Association of Life Insurance Medical Directors. From 1926 to 1928 he was Vice-President, and in the latter year was elected President of the Association.

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UNCONQUERED MENACES

(Herald-Tribune, April 9)

The announcement of the United States Public Health Service that 2 scientists working unofficially in their laboratories, Dr. T. J. Glover and Dr. J. L. Engle, have produced a typical cancer in a guinea pig by inoculation with supposed germ-carrying material from a human cancer constitutes by no means the first report of a supposed germ origin of this still unconquered disease, and presumably by no means the last. Perhaps the obvious deduction of a germ origin for for the disease is correct, but it is too soon to be sure of this. Laymen will do well to remember, until the new conclusion is tested thoroughly by other experts, that the one sure thing about this most dreaded and perhaps most devastating of all diseases is that it begins slowly and can be cured, without benefit of theories of origin, if it be discovered and treated in time. Whatever may cause cancer, there can be no dispute about the fact that it is fatal if left alone and curable if treated in the beginning. Mere appreciation of this fact, however insignificant to the specialists trying to solve cancer mysteries, would save hundreds of thousands of American lives each year.

Scientific medicine always has had 2 aims, not easily reconcilable. Its purpose is to discover the causes of disease; partly so that this may lead to practical cures, partly so that students of the subject may satisfy their curiosity about what germs or other entities are at the roots of the disorder. It happens naturally that most attention is paid to the diseases the causes of which are unknown, for both aims, the practical and the theoretical, are mutually focused on these. It is probably safe to say that three of these take first rank: cancer, diabetes and heart disease.

In the present state of medical science, if a person escapes all other diseases, he or she will die of heart disease. This danger passed, diabetes is the next hazard. Cancer is the third. Given good luck with automobile accidents, measles, diphtheria and others, and still more good luck to escape diabetes and heart disease, cancer is the final hazard to which a majority of us must yield. Heart disease commonly is regarded, probably correctly, as a mere indication that the weakest and most used part of the bodily machinery has given out. Diabetes it is safe to call the most frequent symptom of break-down of the body's complicated system of chemical manufactories which physiologists call the glands. Cancer has been the most mysterious of these 3 unconquered menaces, because there has been no inkling of what part of the bodily machinery had given way. If the new conclusions from Washington stand the tests of time and repetition, the list of unconquerable menaces to long life will be reduced by one, and a substantial one.

Dr. Foster Kennedy has been appointed Consulting Neurologist to the New York Polyclinic Medical School and Hospital.

Dr. Wells P. Eagleton, of Newark, New Jersey, was one of three surgeons who were invited to conduct a Post-Graduate Course in Otolaryngology at the University of Michigan at Ann Arbor, Michigan, during the week of April 24, 1933. His clinic was devoted entirely to diseases of the petrous apex and of the sphenoidal sinus and their relation to intracranial complications.

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VIEW OF THE GROUNDS



APPROACH

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ONE HEALTH BOARD URGED IN ORANGES

(New York Times, April 6)

Leaders of the Welfare Federation of the Oranges and Maplewood discussed plans for bringing before the government bodies of the four Oranges and Maplewood the question of establishing a common Health Department for all five municipalities in the interest of economy and without injecting the issue of municipal or regional consolidation into the proposal.

Consolidation of the Oranges and Maplewood into one municipality or with Newark and other communities of Essex County has been a political football for many years. The proposal has never made definite headway, not alone because of its political implications but because of home rule sentiments among the population.

Welfare leaders interested in a consolidation of health administration, however, stress their view that politics would have no place in consideration of the proposal they make, inasmuch as the residents of the several communities "would benefit healthfully and economically from one-department administration."

A common Health Department has been recommended by a special planning commitee of the health group of the Council of Social Agencies, a member organization of the Welfare Federation. This committee was headed by Dr. George T. Palmer of Maplewood, whose research work in public health includes a study of child welfare in 86 American cities during the Presidency of Herbert Hoover.

Other members of the committee were Mrs. Russell Colgate, wife of the president of the federation; Mrs. William A. Barstow of Llewellyn Park, West Orange, and Robert N. Brough of East Orange. Mrs. Colgate acted as vice chairman. Bent Taylor, associate director of the federation and director of the council, was secretary of the committee.

In a report written by Dr. Palmer and approved by the committee it was pointed out that a consolidation of health administration would make possible centralized nursing supervision, the use of one laboratory, the advantages of more uniform regulations and procedures and the benefits that would accrue from the utilization of facilities by the larger population unit, providing an opportunity for a more balanced and efficient program.

Although there are now a number of common health agencies for the five municipalities, none of these infringes upon separate municipal control, as would be the case if the proposed consolidation of all five health departments were adopted. Such a step, in the opinion of some citizens, would be a major one in the direction of complete consolidation; others take the stand that the question is one of improved health service at less cost, and is not a political issue.

Dr. Russell L. Cecil has been appointed Professor in the Department of Internal Medicine, and Attending Physician to the New York Polyclinic Medical School and Hospital.

Dr. Joseph E. J. King has been appointed Clinical Professor in the Department of Neuro-Surgery at the New York Polyclinic Medical School and Hospital.

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WIDE SUPPORT IN DRIVE REPORTED FOR STATE TUBERCULOSIS LEAGUE

(Newark Evening News, April 6)

State-wide participation of tuberculosis and health associations in the sixth annual early diagnosis campaign was reported by Ernest D. Easton, executive secretary, at a meeing of the exectuive committee of the New Jersey Tuberculosis League at the Robert Treat Hotel.

Mr. Easton reported many associations are demonstrating the use of the tuberculin test as a diagnostic measure. The tuberculosis associations are gaining because of their aid in the anti-diphtheria campaign, he stated, as parents who have observed no bad effects from the Schick test and toxin-antitoxin treatment are readily assured of the harmlessness of the tuberculin test.

Indorsement and coöperation of Parent-Teacher associations, the State Department of Education, the State Department of Health and the State Medical Society were reported. A film, "Story of My Life," which portrays scenes at Valley View, Passaic County's Sanatorium, is being shown at schools and club meetings.

Dr. B. S. Pollak, medical director of Hudson County Hospital and Sanatorium, reported special Negro health week campaigns in most counties. Essex, Hudson, Bergen, Middlesex and Morris are holding meetings and special clinics, he said.

"Essentials in a Tuberculosis Program" will be discussed at the workers' Spring conference at Asbury Park May 12, according to a report by Miss Jane J. Packard, committee chairman.

Those present included: Dr. Martin H. Collier, Camden County; Dr. B. S. Pollak, Hudson; Dr. J. Bennett Morrison, Essex; Dr. Charles I. Silk, Middlesex; Dr. Samuel B. English, Hunterdon; Miss Evelyn T. Walker, Monmouth; Dr. John E. Runnels, Union; Dr. M. W. Newcomb, Burlington; W. L. Kinkead, Bergen; Mrs. Caroline R. Sherve, Atlantic; Dr. Joseph R. Morrow, Bergen, and Commissioner William Ellis, Mercer.

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I think your powder is a little better than you advertised it; you said it would shed water like a duck. Well I believe a duck would leak a little if it would stay in water for 5 years without coming out. I am almost sure the can of powder had been in the well for at least 5 years, if not longer.

Yours truly,

Joseph Murphy,
West Louisville, Ky.

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Journal of The Medical Society of New Jersey

Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Vol. XXX., No. 6 ORANGE, N. J., JUNE, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

SOME SURGICAL CONSIDERATIONS IN THE REPAIR OF OBSTETRIC TRAUMA

John R. O'Sullivan, M.D.,
Assistant Obstetrician, Margaret Hague Maternity Hospital,
Jersey City, N. J.
and
Bernard A. O'Connor, M.D., F.A.C.S.,
Attending Surgeon, Margaret Hague Maternity Hospital and West Hudson Hospital,
Kearny, N. J.

It is not our purpose to enter into a long and involved technical discussion of methods, nor to present excerpts from the literature, but rather to describe in a straightforward manner the practical methods, instruments and technic, developed from an extensive obstetric experience in the wards and delivery room of a very active maternity hospital.

The operation and technical details of choice for any given surgical procedure should be those which are easy to perform, do not violate mechanical or physical laws, give a high percentage of permanent cures with good function, and have a short period of disability. We feel that these principles should guide the obstetrician in any course of action he may wish to pursue in dealing with the surgical repair of trauma incidental to childbirth.

It should be a recognized function of any well-regulated maternity hospital to furnish not only skilled medical and nursing aid to obstetric patients, but also to develop simple and effective methods and instruments which may be carried into the home. Our drawings illustrate and text describes such methods and instruments, and with the exception of the abdominal retractor employed in Cesarean section, these instruments and sutures may be used to great advantage in those difficult situations so often arising in the home; to carry one over a difficult situation which, quite often, the average physician has to handle without professional aid.

In a previous communication, we described a simplified abdominal retractor and the technic employed in its use for abdominal surgical procedures. The intelligent use of this instrument enables the surgeon to secure and maintain a good exposure of the pelvic and abdominal viscera. It releases the hands of the assistant from merely holding retractors and allows him to aid the surgeon in the actual intra-abdominal manipulations, the end-results of this effort being a material reduction of the time required for the performance of any given abdominal procedure with more careful consideration to hemostatis and asepsis.

It is with the above considerations in mind that we approach a discussion of obstetric trauma inflicted upon the uterus, cervix and perineum during the course of labor.

For the purpose of completeness we shall divide these injuries into a consideration of the repair of immediate and late injuries, and at the same time illustrate and describe some practical instruments and methods used by us when handling such injuries.

Surgical Treatment of Trauma to the Uterus

Injury to the uterus during labor may be accidental, such as a rupture due to any of the well-known predisposing factors, or it may be

surgical, incidental to a Cesarean section performed in strict accordance with the orthodox indications.

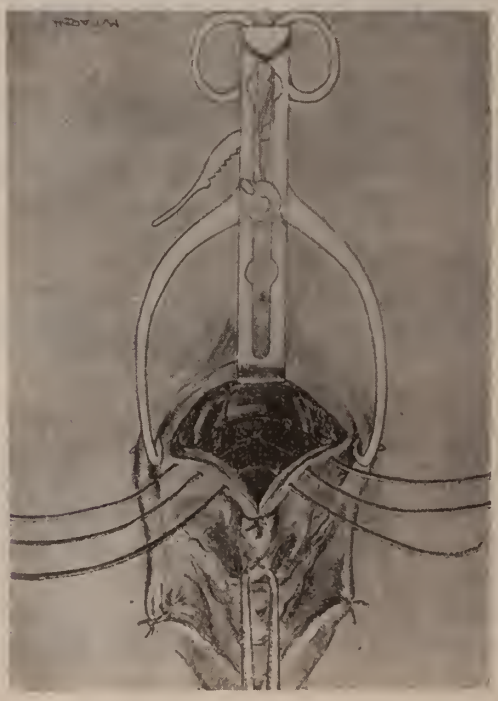
Accidental injury. The abdominal cavity is opened through a low paramedian incision; peritoneum incised in the usual manner; automatic abdominal retractor inserted in the wound and opened laterally by spreading the retractor apart with both hands and the long deep blade is then inserted in the lower angle of the wound and fastened by a wing-bolt. The purpose of this retractor blade is not only to restrain the abdominal wall at the part, but also to protect the bladder and ureters from injury by depressing them downward and backward. If the uterus is relaxed, 1 c.c. of pituitrin is injected directly into the uterine musculature; the purpose being to induce a contraction of the uterus which, in forcing blood out of the uterine cavity through the point of rupture, into the peritoneal cavity, will outline the ruptured area and save time and further exploration. Depending upon the condition of the uterus and of the patient, the point of rupture is carefully closed with a double row of interrupted sutures; or, if considered necessary, a routine supra-cervical amputation of the uterus may be done, particularly if it is feared that subsequent infection, or fragmentation of the uterine musculature incidental to such an accident, may give rise to an uncontrollable hemorrhage later.



Showing method of opening our vaginal retractor by a spreading action with index finger of each hand.

Surgical Trauma to the Uterus Incidental to Cesarean Section

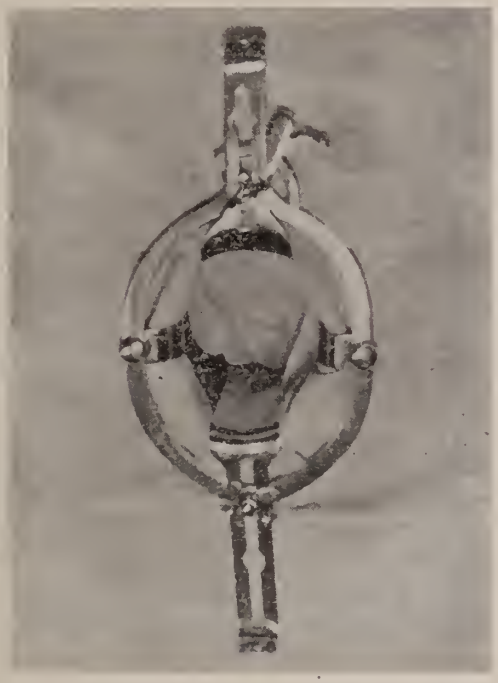
The abdominal retractor is not inserted in the wound until after delivery of the baby. Prior to delivery, the uterus is elevated into the abdominal wound by means of silkworm gut traction sutures, 2 on each side, approximately 3″ apart, and held by artery clamps in the hands of assistants. Immediately after birth of the child, and expression of the placenta, 1 c.c. pituitrin is injected directly into the muscle of the uterus, the silk-worm gut traction sutures are withdrawn, and the automatic abdominal retractor inserted in the following manner: (Figs. 1 and 2.)



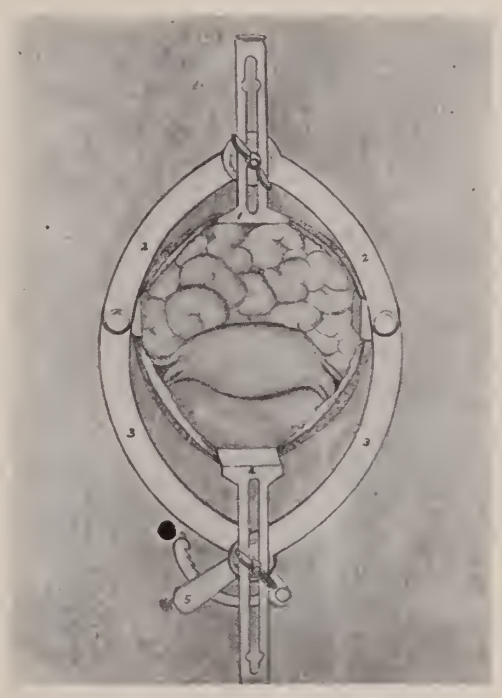
Our modification of Gelpi retractor with middle blade cutaneous drawing down mucovaginal surface, elevating levator ani into view. Kangaroo tendon sutures in place.

The side retractor blades are placed in the wound and the frame opened laterally, both

hands, to the maximum opening permitted by the incision. The deep, wide blade is placed in the lower angle of the wound, reflecting the bladder downward and protecting the ureters. A few packs may be placed in the upper angle of the wound, and the upper angle retractor inserted to furnish counter-traction which will hold the entire frame securely in place, prevent it from rotating within the abdominal wound, and the uterus is then sutured in layers, using either interrupted or continuous sutures, depending upon the surgeon's preference.



Our vaginal retractor in place with upper and lower blades in place. Exposure for repairing cervical and upper vaginal tears.



Hysterectomy. Both adjustable blades in place, showing the adequate exposure obtained before the viscera are excluded by packs. No. 1, upper angle retractor blade. No. 2, upper side arms. No. 3, lower side arms. No. 4, lower angle retractor blade. (Reproduced through the kind permission of the American Journal of the Medical Sciences.)

Immediate Repair of Cervix

There is no doubt that the soft, friable, abnormally dilated cervix is subjected to more or less trauma during the course of child-birth. The relative size of the passenger and the passageways, the presentation, the skill and patience of the obstetrician, and instrumental intervention, are a few of the factors which directly contribute to cervical trauma.

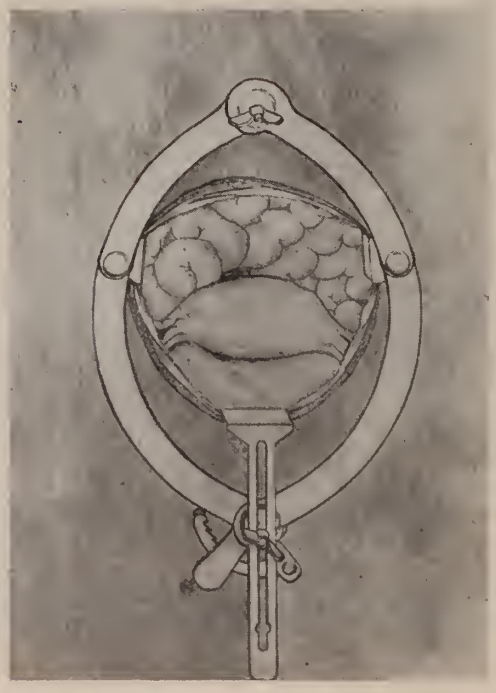
Examinations and observations on our part show that more cases of abnormal postpartum hemorrhage, occurring during the first few hours postpartum, are due to tears of the cervical canal involving the blood vessels, than to either uterine atony or retained placental tissue. It is a surprising fact that this bleeding is not always associated with a deep tear in the fornices. We have seen a considerable degree of hemorrhage arise from an apparently insignificant tear of the cervical canal an inch or so above the external os.

Our attitude toward every obstetric delivery is, that the time to avoid complications is while the patient is still on the delivery table, and not an hour or more afterward. For, it is then that these hemorrhages begin to assume alarming proportions. After we have assured ourselves that the uterus is firmly contracted and the placenta has been delivered intact, we insert our small retractor No. 4 into the vagina, draw down the anterior and posterior lips of the cervix with 2 sponge forceps, and examine the cervix for bleeding vessels or lacerations. An artery clamp is placed on the

vessel and the bleeding controlled by a ligature fastened by a suture. Lacerations more than a finger-breadth in extent are routinely closed by sutures drawn tightly enough to approximate the tear but not so tightly as to cut through the tissues included.

Late Repair of Cervical Tear

To secure an adequate exposure of the cervix, we employ our vaginal retractor (No. 4), using the short blades. An important factor in the repair of cervical lacerations is to secure a bloodless field, if possible. The cervix



Hysterectomy. Lower angle retractor in place exposing the bladder and uterus. (Reproduced through the kind permission of the American Journal of the Medical Sciences.)

is grasped by its lower lip and drawn downward and outward until the everted fold of the vaginal canal prevents further descent. Then, 2 curved Jacob's Vulsella forceps are inserted laterally, as far as possible into the vaginal canal, and then fastened across the cervix, including as much of the cervical tissue within their grasp as is possible in this position. When these clamps are tightly closed they reduce to a minimum the blood supply to the cervix and permit the operation to be carried out with less obscurity from the blood which will flow so freely while the denudation process is being performed. Coaptation of the denuded cervical surfaces is effected with No. 2 chromic cat-gut. The first suture is passed at the upper angle of the tear on one side, from the vaginal mucosa, through the muscle and just short of the intracervical mucosa, reentering the muscle at a corresponding point on the opposite lip to be passed through the vaginal mucosa. These sutures are placed at intervals of ½" until the tear is closed, and tied tightly enough to secure coaptation without constriction.

Immediate Repair of Trauma of the Perineum

After the birth of the child, and while waiting for separation of the placenta, the perineum should be carefully inspected for tears. To secure a bloodless field, a sterile pad is inserted into the vaginal canal as far as the cervix, the labia are separated by a Gelpi perineal retractor, with the third blade restraining the anal margin of vagina. With this instrument firmly secured in place, the vagina may be drawn forward and upward in such manner as to expose the perineal body injury and vaginal mucous membrane between the cervix and external introitus. First, second and deeper lacerations are repaired with chromicized No. 2 kangaroo tendon, for both the muscle sutures into the levator ani and the mucous membrane. Lacerations involving the anal sphincter and rectum require careful repair of the sphincter, rectal mucous membrane, and levator ani muscle. For this purpose, the lateral prongs of the Gelpi retractor are placed in position as shown in Fig. 5. The middle blade, with the hooked end, is placed over the external and rectal surface of the laceration and then drawn downward and fastened by the thumb-screw. The purpose of the middle retractor blade is to stretch the axis of the laceration downward and forward, drawing the separated fibers of the levator ani muscle together in the midline, and thus facilitate placing of the repair sutures. The modified Gelpi which we use, in addition to performing this function, maintains exposure of the internal vaginal portion of the laceration; an e posure which we consider an important step in

consummating immediate repair of perineal tear.

Should the laceration be found to extend deeper, then the separated borders of the levator ani muscle are explored with the finger and the thickest portions are selected through which sutures of No. 2 chromicized kangaroo tendon are placed. Usually, 3 or 4 such sutures are enough. They are then tied tightly enough to coapt the separated fibers of the muscle but not to constrict them unduly. Following this step, the internal limit of the laceration in the vaginal mucous membrane is grasped with an Allis clamp and held upward under tension while a row of interrupted sutures of the same material is placed through the mucous membrane. These are tied and 2 or 3 sutures are placed through the labia through the sutured perineal body, and out on the opposite labia, where they are tied after the skin is closed with a few interrupted sutures. The purpose of these sutures is to control bleeding and afford a highly resistant support against breaking down should the tissues become infected, a very important factor with regard to permanency of the repair.

Lacerations involving the rectum and anal sphincter are repaired in the same manner after closing the rectal tear; the severed ends of sphincter muscle being caught by sponge forceps, drawn upward, and the fascia surrounding this muscle sutured together, after which, the repair may be continued, as above. Chromicized kangaroo tendon, as a retention suture, is highly resistant to the softening and proteolytic effect of the lochia, an effect which tends to destroy the repair.

Late Repair of Perineal Trauma (Perineorrhaphy)

Before entering upon a discussion of the surgical steps involved in the repair of perineal injuries resulting from childbirth, it is not out of place here to discuss the mechanical and anatomic factors, the proper consideration and evaluation of these being intimately involved in the success of this operative procedure. The rectocele resulting from injury to the levator ani muscle during childbirth should be considered as a herniation of an abdominal viscera through a weakness in a muscle-fascia membrane, in exactly the same manner as we consider umbilical, incisional, ventral and coccygeal hernia, and the surgical treatment of this condition should be considered, evaluated, and performed with the same degree of care and attention to the proper and careful approximation of tissues involved as in these hernias. All activity of the patient which tends to increase intra-abdominal pressure, such as coughing, sneezing, laughing, straining at stool, tends to increase the size and the subsequent discomfort of this rectocele. We feel that the studies of B. H. Goff, on the perivaginal fascia in a nullipara, are of the greatest importance in the consideration of perineal repair. He says: "When using the term 'fascia' in descriptions of vaginal plastic operations, it is important to stress the fact that the fascia referred to is not of the dense type, such as is the sheath of the rectus muscle, but is of the loosely arranged areolar type, and that many gynecologists have applied the term fascia to the muscular coat of the vaginal wall, which is situated just beneath the vaginal mucosa, because it somewhat resembles a layer of dense fascia, in its gross appearance. It is obvious that such use of the term 'fascia' is not in accord with classical histologic description of the tissues which constitute the vaginal wall." (Surg., Gynec., and Obst., 52:32, January 1932.)

In view of these findings, it is logical to assume that the failures which we encounter after routine perineorrhaphy are due in a large measure to a lack of suitable tissue to bind together the separated fibers of the levator ani into a good repair. In this connection, it occurred to one of us that the work of G. W. Horsley on the behavior of alcohol-preserved fascia lata of the ox, autogenous fascia, and chromicized kangaroo tendon in dog and in man (Ann. Surg., 1931, 89:410) offered at least a partial solution of this difficulty. It occurred to us that the use of chromicized kangaroo tendon in repair of the levator ani muscle would not only be highly resistant to infection, but would also act as a scaffolding upon which the subsequent fibrosis incidental to the operation could be laid; thus helping to regenerate a fascia to restrain this hernia, much in the manner that fascia lata

is used to repair large ventral and direct inguinal hernia. We instituted this innovation in several cases and, to date, feel that union of the rectocele obtained is quite satisfactory. The Gelpi retractor is placed in the vaginal orifice and opened laterally as far as possible, putting the vaginal mucocutaneal juncture under tension, and an incision is made along this line and the vaginal flap reflected backward in the ordinary manner. After this flap has been reflected backward about 1" from the center, the third removable blade is placed over the center of the incision line and drawn tightly downward, reflecting the edges of the levator ani muscle inward in a fold, and then, after the dissection is complete, 4 No. 2 chromicized kangaroo tendon sutures are placed in the body of the levator ani muscle on each side, drawn tightly over the rectum, and tied; then the redundant vaginal mucous membrane in the flap is cut out and the perineorrhaphy is closed; in the manner of employing silkworm retention sutures through the sutured levator ani body, as described above.

The perineum after childbirth goes through a period of involution qualitatively, the same as the uterus. The success and permanency of perineal repairs depend to a large extent upon the selection and use of an absorbable suture material which maintains its tensile strength for a period of 10 to 20 days in the presence of protolytic enzymes or infection. We feel that chromicized kangaroo tendon makes an ideal suture material for these conditions.

ELECTROCARDIOGRAMS OF MENTAL PATIENTS

II. A Further Report on a Total of Patients

Louis Levin, M.D.,
From the Department of Electrocardiography, State Hospital,
Trenton, N. J.

In a previous communication (Levin, Louis: "Electrocardiograms of Mental Patients", Jour. Med. Soc. N. J., 29:140, Feb. 1932), several points of importance were stressed, namely: (1) The high incidence of heart disease in mental patients; (2) the large percentage of diagnoses dependent upon the electrocardiogram; and (3) the necessity, because of incoherent histories and unreliable subjective symptoms, of routine electrocardiograms. That study was based upon 744 patients. An additional 1156 have been since studied. In most of the following comparisons the similarity of figures is striking, each series thus lending credence to the other because of this close approximation.

Incidence of Organic Heart Disease

Of 1156 patients, 169 (14.6%) had organic heart disease. This closely follows the first report, when 14.2% of 744 patients were found with organic cardiac disease. Of the 169 with diseased hearts, 115 (68%) had physical signs pointing to this pathology. The remaining 54 (32%) had no demonstrable heart disease upon physical examination. The diagnosis of organic disease was based upon those electrocardiographic signs generally accepted as pathognomonic of that condition; 70.7% and 29.2% for similar groups were reported in the first communication.

The high morbidity rate for organic heart disease in mental patients, 14.4% of 1900, is explained in part by the fact that many of these individuals have definite and advanced arteriosclerosis. An independent study is being made to determine the proportionate representation of heart disease in various age-groups. While, undoubtedly, the greatest number of sclerotic patients will fall in that age-group of 60 years and over, it can be said, as a preliminary conclusion, a proportionately large number of younger patients will be found to have developed arteriosclerosis. This was noted by Conner and Holt (Conner, L. A., and Holt, E.: "Subsequent Course and Prognosis in Coronary Thrombosis", Am. Heart Jour., 1930, v, 705): "* * * often, at least, visceral arteriosclerosis must begin at a much earlier age than we have been accustomed to believe." In my own analysis of 83 patients with angina pectoris, 56% had their first attack before the age of 56, and in a series of 21 patients with coronary occlusion, 40% developed their infarct before the age of

56. (Levin, L.: "Precordial Pain", Med. Jour. and Rec., 1931, 133:132.)

Abnormal Waves

The significance of abnormalities in T1 and T2 is well understood. It is also well known that certain deviations of the P wave furnish inferential evidence concerning the state of the auricles. Concerning the meaning of abnormal T3 waves, informed opinion is not unanimous. In this series abnormalities of the P wave and T3 wave were found too frequently to warrant the belief that all or even a large percentage were the result of disease.

A comparison of the abnormal *T1 and T2 waves* in the 2 series reveals but a minor difference. In the first group of 744, 40 (5.37%) were found to have an abnormal T1, and 41 (5.5%) had an abnormal T2 wave. By an abnormality is meant an inversion, a diphasic curve, or an iso-electric status. In the second series of 1156, 48 (4.15%) had an abnormal T1 and 65 (5.6%) an abnormal T2. No comment is required because the percentages found indicate a conservative interpretation of the tracings.

T3 was found abnormal in 365 (49.0%) of the 744 electrocardiograms making up the first series. In the series reported at this time 548 of 1156 (47.4%) were abnormal. The conclusion seems inescapable that abnormal T3 waves have no significance. Neither mental disease nor heart disease can account for this large incidence.

Abnormal *P waves* were found more consistently in the second series than in the first—301 (26.9%), 110 (9.5%), and 365 (31.5%), as compared to 155 (20.8%), 68 (9.1%), and 119 (15.9%), for leads 1, 2, and 3, respectively. Excepting auricular fibrillation, there were only 2 instances of P wave abnormalities in all three leads. There can be drawn from these figures no generalizations, except that alterations of the P wave in one or two leads are not necessarily indicative of auricular disease. Nor can it be said that insanity produces such alterations. Such a position is scientifically impossible and hardly merits the space given for its refutation.

Axis Deviations

In this series, left axis deviation (S3 greater than S1) was present in 275 (23.7%) tracings, and right axis deviation (S1 greater than S3) in 87 (7.5%). This compares with 23.9% and 12.0% for left and right axis deviations in the first series of tracings. An attempt to evaluate the significance of these findings does not meet with pre-eminent success. It is perfectly obvious that cardiac enlargement does not account for the large percentage of deviations, a total of 31.2%. Likewise, the physical build of this group can not be said to be so characteristic as to be significant in one-third of the total number. It is true that the height of the diaphragm, in that it alters the position of the heart, may influence the production of deviations. Thus the thin and the obese may present deviations. But there still remains a large group of unexplained axis deflections. Apparently it is possible for an individual of average build without cardiac enlargement to present such a deviation due perhaps to a developmental variation in the relative position of his heart.

Sinus Tachycardia

Sinus rate was above 105 per minute in 230 (20.5%); in the first series, 120 (16.1%) were found with this condition. Several factors are to be considered in the production of this mechanism. To determine the relative importance of this condition, the possibility of organic disease, anemia, focal infection, and the excitement incidental to the mental state must be borne in mind. Focal infection that is not otherwise obvious, may be suspected because of a persistent tachycardia.

Other Signs

The appended table indicates the incidence of various electrocardiographic findings. A comparison with the first series and an average incidence is presented.

Practical Application

Dry statistics neither interest the eye, nor stir the mind. They are tolerated, but never encouraged. Without a moral the sermon is lost. Without a practical application, statistics lose their value.

Finding	First Series Patients	First Series Percentage	Second Series Patients	Second Series Percentage	Total	Average %
Tracings	744	100.0	1156	100.0	1900	100.0
Organic heart disease	106	14.2	169	14.6	275	14.4
Abnormal physically	75	70.7 of 106	115	68.0 of 169	190	69.0 of 275
Normal physically and abnormal EKG	31	29.2 of 106	54	32.0 of 169	85	30.9 of 275
Inverted T1, T2						
T1	18	2.4	13	1.1	31	1.6
T2	13	1.7	14	1.2	27	1.4
Iso-electric T1, T2						
T1	17	2.3	15	1.2	32	1.6
T2	16	2.1	25	2.1	41	2.1
Diphasic T1, T2						
T1	5	0.6	20	1.7	25	1.3
T2	12	1.6	26	2.2	38	2.0
Total abnormal T3	365	49.0	548	47.4	913	48.5
Inverted	203	27.2	232	20.0	435	22.8
Iso-electric	125	15.4	164	14.1	289	15.2
Diphasic	37	4.9	148	12.8	185	9.7
Abnormal P waves						
Lead 1	155	20.8	301	26.9	456	24.0
Lead 2	68	9.1	110	9.5	178	9.3
Lead 3	119	15.9	365	31.5	484	25.4
Left axis deviation	178	23.9	275	23.7	453	23.8
Right axis deviation	90	12.0	87	7.5	177	9.3
Sinus tachycardia	120	16.1	238	20.5	358	18.8
Sinus bradycardia	15	2.0	5	0.4	20	1.1
P-R interval above 0.20 sec.	7	0.9	0	0.0	7	0.2
Low voltage (5 mm. or less)						
Lead 1	58	7.7	80	6.9	138	7.2
Lead 2	18	2.4	35	3.0	53	2.7
Lead 3	92	12.3	260	20.7	352	19.3
Excessive voltage (20 mm. or more)						
Lead 1	11	1.4	12	1.0	33	1.6
Lead 2	39	5.2	33	2.8	72	3.7
Lead 3	11	1.4	9	0.7	20	1.1
Auricular fibrillation	4	0.5	7	0.6	11	0.5
Ventricular premature contraction	21	2.8	13	1.1	34	1.6
Auricular premature contraction	2	0.2	10	0.8	12	0.5
Nodal premature contraction	0	0.0	2	0.16	2	0.1
Right branch bundle block	3	0.3	1	0.08	4	0.2
Intraventricular block	7	0.9	9	0.7	16	0.7
S'no-auricular block	0	0.0	1	0.08	1	0.05

Auricular paroxysmal tachycardia, auricular flutter, and nodal rhythm were found each once in 1900 tracings.

A State Mental Hospital is a general hospital specializing in the treatment of mental diseases. It has, therefore, the same problems of diagnosis, treatment, and research with which a general hospital must cope. It can not be considered as an isolated self-sufficient medical unit, permanently independent of assistance from other departments of medicine. The welfare of its patients as well as scientific good judgment prohibits such an attitude of isolation.

The study recorded in this publication is an example of the above medico-mental relationship. Since co-existing organic physical disease may make up in part the etiology of the mental status in a given patient, the rehabilitation of the patient demands a complete investigation of his physical condition.

The importance of this statement becomes evident when one recalls that of the patients studied in both groups, 275, or 14.4% of 1900, had organic heart disease. Of this number, 85 or 30.9% of 275, were discovered by means of the electrocardiogram, the physical examination having been grossly negative, and the history unreliable.

Acknowledgment is made gratefully to Drs. H. A. Cotton, and R. G. Stone, Director Emeritus and Director, respectively, of the State Hospital at Trenton, for permission to use the above material, and to Mrs. T. M. Johnson, for her technical assistance.

SOME TRENDS IN MODERN MEDICINE

Joseph Schapiro, M.D.,
Medical Director of Union City Public Schools, and Clinical Assistant in the Pediatric Division, Mt. Sinai Hospital,
New York City

In the brief time allotted, it is only possible to touch upon high spots in the modern trend of the practice of medicine. The changes are so vast and rapid that the physician must continually study, weigh, measure, and sift the good from the bad, and adapt himself so that he may keep pace with progress. In this mechanized world, even medicine, used in the broader sense, has not escaped this new science that is at present being so widely discussed—technocracy.

The practice of medicine is now so highly organized and developed that *specialization* is its natural outgrowth. The enormous increase in scientific knowledge and technical skill, the elaborate armamentarium that has come into existence as a result of scientific research, has glutted the market with so many instruments of precision (many of doubtful practical value) for diagnosis and treatment, that the average patient and doctor are alike bewildered and awed by their mere display; let alone the many gadgets and sparks and buzzing and humming and sizzling effects let loose by their manipulation. How much of value these scientific instruments have accomplished in the matter of making better diagnoses or procuring more effective treatment, is a matter of conjecture. This, it has achieved: dependence upon mechanical appliances rather than upon the senses we were so zealously taught to develop and use in days gone by. But, of one thing we are certain, and that is, that society has been making demands of the physician which have resulted in bringing into the medical field: highly organized medical centers; pay clinics; diagnostic laboratories; consultation clinics; elaborate hospitals and dispensaries; industrial medical services with hospital facilities and subsidized physicians, surgeons, and public health nurses; baby welfare stations; pre-natal and birth-control clinics; rehabilitation clinics under state and federal control; and a host of physicians, surgeons, and nurses on a salary basis.

Society is demanding of the physician *this* "special" examination and *that* "special" treatment, until the cost of medical care has naturally increased. If this demand by society is not soon checked, the time will not be far distant when medical services will be rendered much in the manner that merchandise is dispensed over the counter. These demands on the part of society, and ready compliance by the medical profession, have led to other changes. "Group practice" had to come into existence and is in operation in various parts of the country, so highly systematized that in some localities these groups operate in the manner of the big corporate industries. The personal relationship between physician and patient, so important in the practice of medicine, is swept out of existence. The patient is the "case"; the doctor, the mechanized robot. Gradual disappearance of the family doctor has been predicted for many years. Now, the medical schools that have turned him out to practice his "noble" profession are competing with him, in the form of medical centers staffed by experts and run on a factory basis. If the people are lulled into the belief that they are getting "expert" service for nothing, or at "nominal" cost, they had better awake from their lethargy. Let me cite just one example of "efficiency" and "nominal" cost service: A child, aged 11 years, applied at a well

known medical center for correction of vision because she was informed by the school physician that she needed glasses. She was examined and glasses were prescribed, and the cost was $20. If this is charity or "nominal cost" service, I fail to see it. This is not the whole story. The child began to complain of severe headaches, which were not present before glasses were worn. She was taken to a private ophthalmologist who prescribed different lenses, with the result of securing good vision and disappearance of the headaches. He also stated that this child's eyes might have been seriously injured had she continued wearing the original glasses. Here is a splendid example of group practice in a medical school staffed by "experts".

"Unless we beware," says Dr. Hans Zinsser, "science and art will share the fate of industry. Teachers' colleges will train a standard brand of managers and deans with diplomatized trustees, for large endowments, whose opinions will be packed in neatly tight conclusions, alike as soda biscuits. Coöperative research will congeal the sap of young ideas in their cocoons; and legs will be cut off on moving platforms, a surgeon every yard on either side, and the patient leaving at the farther end, walking on his new wooden leg. Professors will be kept in full-time cages, broadcasting standard discourses and fed on nuts and vitamins (bought at wholesale prices), amounts weighed out according to the subject. Although students shoved in at the bottom may show some slight irregularities, they will come out at the top all evened-out, well-baked and stamped alike in weight and taste, whether from here, the east, the west, the south; except that Chicago, forced by competition, may give a Ford sedan with diplomas. Unless we beware, these things may come about."

"How", it is asked, "can the general practitioner survive, if prestige and emoluments are going to the specialists; if hygienists keep cutting down the output of patients; if free and pay clinics offer the competition of organized service in medical centers; if hospital connections continue to be limited and elusive; if the public fails to discriminate between well trained physicians and obscure healers and cultists?" In Cuba, where the hospital associations have combined to render group service to nearly 250,000 individuals who contribute from $1.50 to $2 a month, for unlimited medical and surgical care, the private practitioner has been practically eliminated—starved out of the profession. He could not compete with practice organized on such a large scale; with unlimited and guaranteed medical care in large, well equipped, modern hospitals; and was forced to accept a full or part-time salaried position or die of inanition. Initiative and ambition were crushed. The Cuban doctor, with the exception of a few wealthy and outstanding specialists, was forced to the wall and became one of the "experts" on the staff of this vast organization.

And this brings me to say a word about the Report of the Committee on the Costs of Medical Care which has just been published. There is no doubt where the physician and the specialist stand with regard to this report. But let me say that we will have to do some "tall thinking" from now on. There are a number of features in this report that need careful pondering, and the doctor in turn will have to "attune" himself to conditions and circumstances in such manner as not to lose his self-respect, his identity or his place in the community. Discussions, carefully conducted in our organized medical groups, local, county, and state, on the various propositions enunciated therein, will go far in clearing up misunderstandings, and crystallizing public opinion in our behalf. We must show tolerance and calm judgment. Let us not draw hasty conclusions.

Unless the radical ideas thrown out for public consumption by "captains of industry" and "health experts" who are absolutely ignorant about the actual practice of medicine, are vigorously combated there is great danger in store for the future of medicine. We are willing to let evolution and natural development take their course. But the physician is absolutely opposed to revolutionary ideas forcibly or otherwise foisted upon him by lay or professional groups who delve into everybody's business but their own. For one thing, society may be reminded that such radical principles will endanger the recruiting of young men for

the career of medicine—that the best abilities may turn to other vocations. The physician stands in danger of becoming a mere cog in a big industrialized machine; an automaton, with all the fervor of ambition for advancement frozen in his blood; a servant, at the beck and call of the people.

If organized medicine means anything, now is the time to show it. The honor and prestige of the physician must be maintained in the community. "In union there is strength." And, as Kipling says:

"Now this is the Law of the Jungle,
And the Law runneth forward and back:
The strength of the pack is the wolf,
And the strength of the wolf is the pack."

TOXIC HEPATITIS (ACUTE YELLOW ATROPHY) DUE TO CINCHOPHEN (ATOPHAN)*

Louis L. Perkel, M.D.,
Attending Gastro-enterologist, Jersey City Medical Center,
Jersey City, N. J.

Increased use of cinchophen and its derivatives for neuritic and arthritic pains, both through self-medication and on physicians' advice, has revealed its potential toxicity. Pharmaceutical manufacturers continue to exploit the numerous allegedly safe preparations of cinchophen and its congeners, often disguised under non-descriptive and misleading names.

Frequent reports of toxic and fatal results emphasize the danger of indiscriminate and uncontrolled use of these preparations. It is deemed advisable, therefore, to report another fatal case with necropsy findings and briefly review the literature.

Report of case. M. C., an unmarried white woman, aged 47, was admitted to the Jersey City Medical Center on October 2, 1931, complaining of jaundice, weakness, loss of appetite and pain in the right hypochondrium.

The family history is irrelevant. She had typhoid fever at the age of 26; had never been pregnant and her last menstrual period was in January 1931; did not use alcohol or tobacco; venereal disease was denied. Prior to present illness she had no gastro-intestinal symptoms.

In June 1931, 4 months before admission, she began to have shifting pains and stiffness in the joints of her hands, elbows and shoulders. She consulted her family physician, who prescribed capsules containing atophan (cinchophen) and sodium salicylate, of each 5 grains, to be taken 1 every 3 hours. June 15 to 19 she had taken 20 capsules, containing a total of 100 grains of cinchophen. Four days after having taken the last capsule, she experienced generalized abdominal pain which soon localized in the right hypochondrium; dull, constant and not related to food intake or bowel movement. She had no nausea, vomiting or disturbance in bowel function. Two weeks after onset of the pain, there appeared a mild, generalized jaundice, which gradually faded, and disappeared in 5 days with complete relief of the accompanying pain.

She remained comfortable for 2 months thereafter, when, on the return of her joint pains she resumed the medication. From September 15 to 24 she took 40 capsules, containing a total of 200 grains of cinchophen. The pain in the right hypochondrium returned with increased severity, she became very weak, and lost appetite. On September 28 (4 days after taking the last capsule), jaundice reappeared, and during the next few days icterus became progressively deeper and weakness more pronounced. At this time (October 2) she was seen by the writer and immediately admitted to the hospital.

Physical examination: She was a poorly nourished woman with an intense universal jaundice. Height, 62 in.; weight, 115 lb., (52 Kg.). All teeth were false. Heart and lungs normal. The abdomen was slightly distended but no signs of fluid could be elicited. The liver was enlarged to 2 in. below the right costal margin and was tender on palpation. The spleen was not palpable. Blood pressure, 130/80; temperature, 100° F.

Laboratory findings: Urine contained a trace of albumin and a few granular and hyaline casts. Tests for sugar, bile and urobilo-

*(This report was received during the Summer of 1932 but Journal space for its publication was not available until the present issue.—Ed.)

gen were negative. Leucine and tyrosine crystals could not be found in the sediment. Galactose tolerance test yielded a return of 4.1 gm. Blood chemistry, leukocyte and differential counts, were normal; erythocytes, 4,000,000; hemoglobin 70%. Blood Wassermann and Kahn reactions were negative. Icterus index was 75 and van den Bergh reaction was immediate direct. The stools were foul, acholic, and the occult blood test gave a faintly positive reaction.

Roentgenographic study of the gastro-intestinal tract showed no evidence of organic pathology. Cholecystography resulted in non-visualization of the gall-bladder and no calculi were seen.

Diagnosis was "toxic hepatitis due to cinchophen". Treatment consisted of absolute bed-rest, high carbohydrate diet and intravenous administrations of 500 c.c. of 10% dextrose, combined with 10 units of insulin, twice daily.

October 3, the patient was fairly comfortable, complaining only of fulness in the epigastrium. October 6, the liver could not be palpated. Icterus index rose to 100 and van den Bergh reaction remained unchanged. October 7, a small subcutaneous hemorrhage appeared in left upper eyelid. She vomited after all her meals and felt weak. Intra-duodenal biliary drainage was attempted but no bile was recovered. The following day she felt better and for 2 weeks the course remained fairly stationary. On some days she appeared so much improved that a favorable prognosis was entertained. October 23, she suddenly became very weak, refused food and appeared drowsy. Her abdomen was distended but no signs of fluid were found. There was no edema in the extremities. Icterus index rose to 130. October 24, there appeared twitching movements in the left arm and eyelids and later in the right arm and both legs. Râles were heard in the bases of both lungs. The abdominal distension increased and signs of fluid were elicited. She became dyspneic and her pulse was very rapid and feeble. October 25, she was in shock, with cold clammy extremities, cyanotic lips and imperceptible radial pulse, passed from semi-stupor into coma, and expired on the following morning.

Necropsy: Permission was obtained for examination of the abdomen only, which was done by Dr. H. Goldberg, with findings summarized as follows: "The skin and sclera are of an intense yellow color. Upon opening the peritoneal cavity through a right rectus incision, there occurs a sudden gush of dark red blood. The abdomen is filled with blood both fluid and clotted. The abdominal organs are in normal apposition. The liver is very small (weight, 400 gm.), brownish green in color and bound down by numerous adhesions to the diaphragm; an increased resistance to cutting. The cut section is granular and is made up of olive-green, brown and red areas. The gall-bladder is small, empties easily and contains a small amount of dark green viscid bile but no calculi. The biliary duct system is patent. The spleen (weight, 180 gm.) appears normal except for an increase in connective tissue shown in its cut section. The kidneys (weight of each 180 gm.) appear normal except for the marked yellow discoloration seen in the cut section, especially in the lining of the pelvis. The pancreas is hard, yellow and covered with blood clots. Cut sections show normal pancreatic lobules separated by infiltrated dark red blood. The gastro-intestinal tract is normal."

The histologic description by Dr. W. Braunstein was as follows: "Sections of the liver show bile pigment scattered throughout. The polygonal cells are markedly degenerated. There is a beginning necrosis about the central veins. Areas of fibrosis and round cell infiltration are irregularly distributed about the bile ducts. The picture is that of a diffuse hepatitis approaching acute yellow atrophy. A section of the spleen shows an increase in interstitial tissue. A section of the pancreas shows well preserved glandular acini and islets between the lobules, with areas of hemorrhage but no necrosis. The kidneys show cloudy swelling. The anatomic diagnosis is: (1) Toxic hepatitis and fibrous perihepatitis. (2) Hemorrhage into the pancreas and into the peritoneal cavity. (3) Fibrosis of the spleen."

Comment: Although cinchophen (atophan) was first introduced by Nicolaier and Dohrn in 1908, only 12 toxic cases were recorded in the literature up to 1913, and all these dealt

mainly with the various toxic skin manifestations. Schraeder, in 1922, reported the first case of jaundice resulting from cinchophen. Since 1926, when Langdon-Brown reported 2 fatalities following the administration of atoquinol, the literature of each year has been augmented by additional cases.

Rabinowitz, in 1930, in an exhaustive review of the literature reported a total of 50 patients with 25 deaths, of whom 20 gave postmortem corroboration. In the same year, Sherwood and Sherwood reported another patient with recovery. Elliott, in 1931, added a fatal case following the use of oxyl-iodide. Beaver and Robertson found a total of 35



Fig. 1. Liver, showing marked diminution in size.

fatalities in the available literature. Obviously many instances fail to reach the literature, due either to neglect of reporting or failure of recognition.

Pharmacology: Cinchophen (phenyl-cinchoninic acid, atophan) is chemically phenyl-quinoline-carboxylic acid. Sutton claims that under certain conditions the decomposition of the quinoline nucleus by the liver yields highly toxic nitrobenzene compounds, similar to those produced in arsphenamine and trinitrotoluene poisoning. By virtue of the failure of the liver to excrete them, these toxic compounds damage the liver and produce jaundice.

There are many preparations containing or entirely composed of cinchophen and its derivatives. Rabinowitz enumerates 19, of which the most common are atophan, neo-cinchophen, tolysin, novatophan, oxyl-iodide, farastan, weldona, atophanyl, fantan, agotan, leucotropin and atoquinol.

All observers agree that in every toxic case there is present either an idiosyncrasy to the drug or a predisposition to the toxic effects thereof by some previous damage to the liver. This contention is supported by the observation that the amount of drug or the duration of its administration do not determine the degree of toxicity. A toxic reaction has resulted from as little as 15 grains taken in 1 day; while, conversely, many patients have been known to take large doses over a period of years without any apparent ill effects.

Pathology and clinical course. The pathology usually found is a degeneration and a compensatory regeneration of the liver cells



Fig. 2. Sagital section of the liver.

of varying degrees, the most destructive of which produces liver atrophy. Thus, varying clinical pictures are produced depending on the relative amount of necrosis and regeneration.

The clinical course is similar to that seen in acute yellow atrophy due to other causes. The most conspicuous symptom is jaundice, pain being usually absent or else not prominent. The onset, which may not occur until several days after the drug is stopped, is usually manifested by gastro-intestinal irritability followed by jaundice. Though the liver may at first be found to be enlarged, it soon diminishes in size while the jaundice deepens. Ascites, edema and splenomegaly may develop if the condition is prolonged. Death may result from hepatic toxemia or from any intercurrent condition such as internal hemorrhage, which was the terminal event in the case here reported. Due to the large margin of safety in the liver, many cases recover with a residual cirrhosis.

Diagnosis. The history of previous use of the drug or any of its derivatives is the most important point in diagnosis. Rabinowitz succinctly states: "The association of the jaundiced state and atrophy of the liver with the use of cinchophen preparations can no longer be considered a mere coincidence."

reinforcing its depleted glycogen reserve. Rabinowitz advocates intraduodenal biliary drainage with magnesium sulphate solution. Eimer strongly recommends this procedure, which he used on a patient who took 118 gm. of cinchophen in 41 days and recovered.

Most important is the preventive therapy.

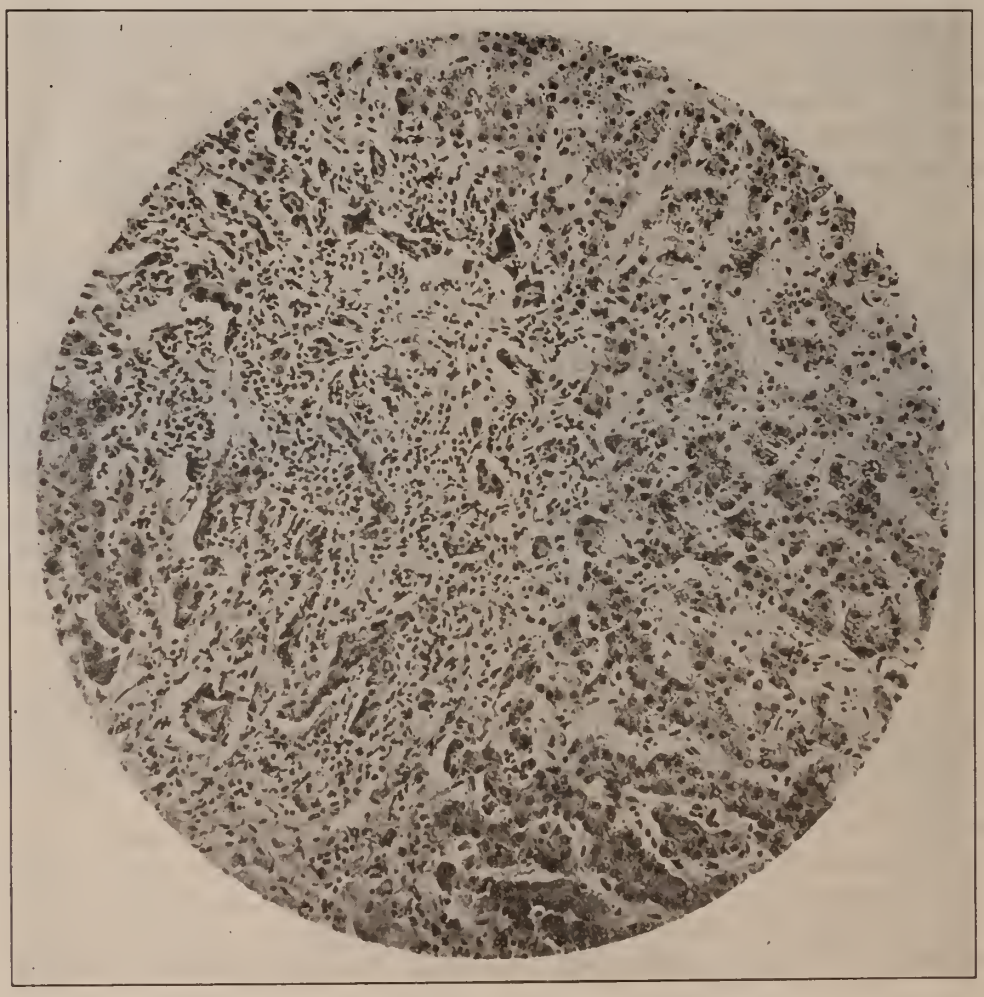


Fig. 3. Section of the liver showing areas of necrosis and fibrosis.

Other considerations in the diagnosis are the relatively painless deepening jaundice associated with diminution in the size of the liver and the ruling out of other causes of jaundice.

Treatment. The accepted treatment consists of absolute bed-rest, forced fluids, high carbohydrate diet and intravenous administration of dextrose supplemented by insulin. Dextrose is obviously indicated to spare the liver by

Except in acute gout, the superiority of cinchophen over salicylates is questionable. If one choses to use it, however, the correct method of administration would be to give it in short courses of a few days and accompanied by alkalis with rest periods between courses. At the first sign of toxicity, as shown by toxic rashes, gastro-intestinal irritability or jaundice, the drug should be permanently discontinued.

PEPTIC ULCER*

Frank Pearlstein, M.D.,
West New York, N. J.

Peptic ulcer occurs in those areas that are subject to the action of gastric juice containing pepsin and free HCl. Therefore, ulcer may occur in the stomach, duodenum, lower end of the esophagus, and also in the jejunum where it has been anastomosed to the stomach. It occurs in at least 10-12% of the population (Bevan), and more often in men than women, and becomes, therefore, an important problem to both physician and surgeon.

Morbid Anatomy. In the early stages an ulcer is symmetrically round, involving the mucosa and burrowing from there into deeper tissue. The edges in recent ulcers are clear-cut, but the loss of substance tends to be conical in form so that greater area of mucous membrane is exposed. In the more chronic cases fibrosis takes place in the ulcer walls. Recent ulcers are red and bleed easily. Old ulcers are yellowish and less acutely inflamed, in appearance. The peritoneum varies, depending upon how deep the ulcer is. If the ulceration is of recent origin the peritoneum appears mottled; if older, it is firm and there is evidence of contraction.

Site. Mostly on the lesser curvature. In long standing cases, where contractions and spasms have taken place, with resulting stagnation, a secondary gastritis results.

Microscopic Appearance. Recent ulcers show more changes in the tissues beneath the mucosa than in the mucosa itself. Although there is loss of tissue in that situation, it is sharply defined and without obvious inflammatory changes in the adjacent mucous membrane; whereas, in the submucosa there are inflammatory changes which suggest this being the site of the original pathologic change. In chronic ulcers the findings are: (1) deeper burrowing; (2) fibrous tissue with contractures.

Etiology. (1) Reeves claims that a large number of arterioles on the lesser curvature end without anastamosis; which accounts for the frequent occurrence of ulcer at that point, probably due to poor local vascularization.

(2) In severe trauma to the epigastrium, ulcer of the stomach may follow. Movements which tend to raise intragastric tension, and the drinking of very hot or cold fluids (Mayo) may start trouble.

(3) While diet is not, in itself, apparently, the cause of ulcer, it will prevent healing by producing pylorospasm and hyperacidity.

(4) Cutaneous burns may produce an acute type of ulceration, usually multiple; more often in the duodenum than in the stomach. There is a toxin produced in burned tissue which circulates in the blood, either in the plasma or absorbed by the red blood corpuscles.

Virchow attributed a causative factor, in ulcer production, to degenerative processes in the walls of the vessels, and to congestion and thrombosis of veins and arteries. Experimentally, this could not be proved. While thrombosis of a vessel in the base of an ulcer is not uncommon, that does not prove that a thrombus caused the ulcer. It is more logical to expect a thrombotic process to result from the inflammatory process which surrounds a chronic ulcer.

(6) There can be little doubt that infection plays an important part in the etiology of some types of ulcer, especially acute ulcers. Whether such acute ulcers become chronic is still a moot question.

(7) *Focal Infection.* Some say such ulcers may be due to a focus of infection in the gall-bladder, appendix, teeth or sinuses. Microbic embolization from a focus to the minute end-arteries of the stomach may produce ulcers. These organisms localize by selective affinity in certain tissues of the body, causing therein secondary areas of inflammation. While bacteria have been found frequently in the base and edges of ulcers they have been considered usually as secondary invaders.

(8) It is probable that certain families have a predisposition to certain toxins, such as tobacco, which in turn has an effect on the neuromuscular mechanism of the pylorus tending to produce spasm of the sphincter pre-

*(Abstracted from a lecture, delivered in one of the Post-Graduate Courses sponsored jointly by the Medical Society of New Jersey and Rutgers University.)

venting regurgitation; therefore, maintaining a high acidity and making at least for one of the elements for ulcer.

(9) Asthenic individuals are probably more susceptible.

(10) Eppinger and Hess, though not claiming that ulcer occurs more frequently in vagotonic individuals, claim that increased irritability of the vagus tends to increase their symptoms, increases pain, hyperacidity and peristalsis, and also shows increased irritability to other parts of the body, such as vasomotor disturbances, spastic colon, slow heart, etc.

The symptoms of gastroduodenal ulcer are pain, vomiting and periodicity of recurrence; with hemorrhage and perforation as complications. The clinical history varies a great deal with the type of ulcer, whether gastric or duodenal; also with the complications. The history may be one of periodic pains and heartburn, with or without vomiting. In some cases the first symptoms may be hemorrhage from perforation.

Pain stands out most prominently. It may be mild, or only in the nature of a heart-burn, or may be more severe and like a boring in the epigastrium occurring at varying intervals after eating; but can be relieved by alkalis or by emptying the stomach.

Heart-burn occurs in varying time from a few minutes to a few hours after eating, and may be mild or severe, and repeated for years. It may exist without pain.

Pain may be located in the epigastrium or just above the umbilicus, and may radiate to the back. Severe pains in the back are probably due to a perforating lesion on the posterior wall, with adhesions to the pancreas. The pain may occur anywhere from ½ to 3, 4, or even 5 hours after eating. It is almost always relieved by food. A light carbohydrate meal gives relief for a shorter period than a heavy protein meal. Continuous pain may be due to adhesions.

Gastric ulcers situated toward the cardia may cause more immediate complaint of pain. In ulcers of the lesser curvature and pylorus, pain comes on about 2 hours after eating. In duodenal ulcer, it comes later, 3 to 5 hours after eating.

Cause of Pain. (1) Hyperacidity acting on the ulcer. (2) Exaggerated peristaltic activity.

Nausea and vomiting, water-brash, and eructations are frequent symptoms in gastroduodenal ulcer. Nausea is accompanied generally by abdominal distress. The vomitus may be fluid or fluid plus food, or with blood. Vomiting usually takes place 2 or more hours after eating. Vomiting, in pyloric stenosis or persistent pylorospasm, may be copious and may contain food eaten days before.

Practically all ulcers show periods of active symptoms, separated by longer or shorter periods of freedom from complaint. In the active stage the typical symptoms are present and may last from a few weeks to several months. The free period, or intermission, may last several weeks or months.

Spring and Fall seem to bring on recurrences; colds, infections, sinus conditions, and grippe do likewise. Diet probably has no effect on recurrence of symptoms. The more severe the ulcer the shorter the free intervals, and the attacks last longer. The appetite is usually good. Patient is usually well-nourished, unless he restricts his diet or has continuous night pains and loses sleep, therefore, weight.

Constipation is more constant in duodenal ulcer, probably due to the hyperacidity, hypersecretion, or to pylorospasm which causes delayed emptying and a general disturbance in gastric motility. Probably, the factors that are responsible for the cause of ulcer (that is a constitutional vagotonia) also cause a spastic constipation.

Physical examination, while practically negative for ulcer, is very important to rule out other conditions.

The pathologic stimuli originating in the viscera are carried to the afferent sympathetic paths to the corresponding spinal cord segment and are reflected outward along the sensory somatic nerve paths of that segment via posterior spinal ganglia and posterior branches of spinal nerves.

The path taken by the nerve stimulus produces a tender zone (head zone) corresponding to the distribution of the affected spinal nerve. The head zones correspond to the

seventh, eighth, ninth dorsal spinal segments. As most of the other abdominal organs have a similar sympathetic nerve supply, it is evident that other viscera may give similar situations of pain. Functional disorders may, likewise, give similar pains. Similar tender areas may also be found posteriorly over the tenth, eleventh and twelfth dorsal vertebrae.

Rigidity of abdominal muscles is a reflex manifestation of disease of a viscus situated in the epigastric region. When perforation occurs we have a board-like rigidity.

Laboratory findings vary, depending upon the motility of the stomach; if motility is normal, we may find a normal amount of acid. Hyperacidity seems more frequent in the pyloric group. Anacidity and hyperacidity have been found in ulcers on the lesser curvature of the stomach.

A complete radiographic study should be made of each patient suspected of having a gastric or intestinal ulcer.

Position—The lower pole may be above or below the umbilicus.

Size—Depends upon its volume. The expansibility is in all directions.

Contour—The normal contour is broken by the incisura cardiaca, incisura angularis and by peristalsis.

Mobility—The fixed points in the stomach are the esophagus and the gastrophrenic ligament at the cardiac end and the hepatoduodenal ligament.

Flexibility—An important characteristic of the normal gastric wall.

Gas-bubble. In the upper part of the stomach there is a transparent area, chiefly due to swallowed air. Its function is thought to keep the walls of the stomach apart and thereby offer little resistance to the entrance of food.

Secretion—In normal fasting stomach is small, so that no accurate estimate can be made during the ordinary x-ray examination.

Peristalsis—The ring-like contractions encircling the stomach which progress to the pylorus and stroke the gastric contents toward the bowel. Peristaltic waves vary in normal individuals; some shallow, others deep.

Motility—Water begins to enter the intestines almost as soon as it enters the stomach. Carbohydrates go through rapidly; proteins more slowly and fats take the longest to empty. Motility is retarded when hard particles are present. No sharp line can be drawn between hypermotility, normal or hypomotility. Motility may be tested by a meal and use of stomach tube, also by x-rays.

Abnormal Stomach

Changes of: (1) Tone (increased or decreased). (2) Position, may be pulled over by adhesions. (3) Contour, niche or infiltrations. (4) Mobility, disturbed by infiltration. (5) Flexibility, not as flexible with infiltrative pathology. (6) Secretion, may be greatly increased as in duodenal stenosis. (7) Peristalsis, greatly increased in ulcer or absent in infiltration. (8) Motility, increased in ulcer when there is no obstruction; decreased in obstructive lesion.

Differential diagnosis. (1) Chronic appendicitis. (a) History of several attacks. (b) May even have hemorrhagic toxic diapedesis. (c) Adhesions resulting from appendicitis may cause gastric symptoms or the appendicular stump may cause irritations in the ileocecal region.

Physical Examination

(1) Tenderness in ileocecal region with radiation toward the epigastrium.

(2) Hyperesthesia; persistent in some cases. It may originate in that part of the segment of the cord from which the spinal nerves emerge supplying the skin overlying the organ. An impulse from the affected organ to the segment of the cord travels from this to the brain and from there efferently to the skin. The process is one of double efferent impulse.

(3) Pain in right loin; hyperesthesia over right loin.

(4) Abdominal reflexes; are increased with hyperesthesia on affected side.

(5) Pain on inflation of colon. (Bastedos sign.)

(6) May also have an associated hyperacidity.

X-ray examination of appendix. (1) size; (2) shape; (3) contraction; (4) motility; (5) mobility; (6) position; (7) tenderness; (8) spasm of stomach (reflexly).

Chronic Gall-Bladder Disease

(1) History in women, who date their attacks to pregnancy or parturition. The free intervals of symptoms as found in ulcer usually absent in gall-bladder. Gall-bladder patient can sleep through the night without pain sometimes, if he eats late at night, because gall-bladder pain is due to distention of the gall-bladder. The gall-bladder is mostly full when the stomach is empty. The reverse is true in ulcer.

Pain is severe, radiates to right shoulder and back.

Pyrosis, which is present during the active stage of ulcer and usually relieved by bicarbonate of soda. In gall-bladder it is present most of the time and aggravated by fat. Gall-bladder patient may not have any hyperacidity or may even be diminished, it is the hyperesthesia of the gastric mucosa that is responsible for pyrosis.

Objective examination. (1) Tenderness on deep pressure over right hypochondrium. Duodenal ulcer seldom tender on deep pressure. (2) Pain in right humero-clavicular joint usually present when gall-bladder is diseased, probably due to pressure.

Treatment of Ulcer. (1) Prophylaxis ought to receive more attention for the reason that many ulcers start insidiously and are preceded by hypersecretion and hyperacidity. If these symptoms were corrected promptly, it is possible that a certain number of cases could be prevented.

(2) Focal infection should also be taken care of, with reference to sinuses, tonsils, and teeth, particularly.

Whatever special treatment method is used the patient should remain in bed during the active symptoms for 1-2 weeks, and have very little work for another month; not only to spare the digestive organs but also the mental and physical condition. There is no doubt that since the loose method of ambulatory treatment of ulcer, more cases are subject to surgery. Duodenal feeding advocated by Einhorn in many cases is satisfactory. The use of alkalis, given because of the frequent presence of hyperacidity, or because of symptoms of hyperacidity, is probably greatly overestimated. Many cases of ulcer can be managed with a minimum quantity of alkalis, provided rest, local heat and dietetic measures are employed. Excessive use of bicarbonate of soda is harmful.

Relative indications for surgery are: Definite, direct and progressive x-ray signs of ulcer, and prolonged conscientious medical treatment failing to produce results; also cases with marked adhesions. *Absolute* indications: Perforations; repeated hemorrhage or pronounced occult bleeding; duodenal stenosis; or diverticulum of the duodenum as result of ulcer.

EFFECTS OF TOBACCO ON ADOLESCENTS*

W. Blair Stewart, M.D., F.A.C.P.,
Atlantic City, N. J.

The extraordinary increase in cigarette smoking and other methods of using tobacco, during the past decade, by growing children has led to an investigation of possible deleterious effects. Tobacco is classed as an acrosedative narcotic poison. Its chief alkaloid, nicotine, is present in different samples of cured leaf in amounts varying from 1% to 6%, and, considering its toxicity, Peterson quotes a case history stating that 12 gr. of pure tobacco, taken internally by an adult, caused death. Another instance is recorded by a man who applied a decoction of tobacco for an eruptive disease and death occurred within 3 hours; every symptom of tobacco poisoning having been present. In still another instance 1 gr. of nicotine caused death in 5 minutes. Decoctions of tobacco, given by enema, as an anthelmintic, are said to have caused death in several instances.

Lee's analysis of 100 grams of tobacco showed: Nicotine, 1.165 gm.; pyridine and colloidin, 0.146 gm.; hydrocyanic acid, 0.08 gm.; ammonia, 0.36 gm.; carbon monoxide, 410 c.c. Smoking (combustion) destroys about 50% of the nicotine; the other 50% being found in the cigar or cigarette butt, the smoke, saliva

*(Read before the American Therapeutic Society, Baltimore, Md., May 17, 1932.)

and lungs. All the gases liberated from tobacco by combustion act as irritants to the mucous membranes of the mouth, tongue, pharynx, larynx and bronchial tubes. Many cases of epithelioma of the tongue and lips in chronic smokers may be due to local irritation produced by the cigar or pipe, plus the irritant effects of the nicotine, pyridine and hot gases. While this is a moot point, clinical evidence weighs heavily in favor of "smoker's epithelioma". Salivary and gastric secretions are markedly increased by tobacco, particularly if smoked when the stomach is empty. Some persons have a decided idiosyncracy to tobacco and are made sick by its use or even by its odor.

The primary effects of one's first experience with tobacco are well remembered by many of those who have tried smoking or chewing. Faintness, vertigo, stupor, nausea, vomiting, nervous depression, feeble pulse, cold and clammy or sweaty skin; and, if used in excessive amount, sometimes convulsions of spinal nerve origin. And yet, with such experiences, children and adults will persist until nature becomes accustomed to these untoward effects and be misled into a feeling of security and a so-called pleasurable habit. The U. S. Dispensatory notes that "it must have properties peculiarly adapted to the propensities of our nature to have thus surmounted the first repugnance to its odor and taste and to have become the passion of so many millions".

Excessive use of tobacco will often induce color blindness and amaurosis. While not the prevalent symptom, many heavy or constant smokers lose or have a weakened virility. A number of such patients under my care in past years were improved or relieved by absolute withdrawal of tobacco. In the young as well as adults there is a true arhythmia, rapid heart action or palpitation. The so-called "tobacco heart" is a real entity but, unless due to a too prolonged abuse of tobacco, disappears when the tobacco is withdrawn. Smoking *raises* blood pressure *primarily* 5-10 mm. Hg. systolic, and 5 mm. Hg., or more, diastolic, by contraction of the involuntary muscles and the increased heart action and respiratory effort. Exertion may cause free smokers some shortness of breath or even labored breathing. When used to excess, tobacco causes *secondarily* a *fall* in blood pressure due to cerebral and vasomotor depression. Peristalsis is increased by the use of tobacco and this reason is often given as an excuse for smoking the morning cigar—to produce catharsis.

"Smoker's angina" or pseudo-angina is sometimes present in the excessive users of tobacco. Many are convinced that true angina cannot be induced by tobacco, *per se;* while many others cite cases with very convincing data. However, it is well known that those who are predisposed to angina have attacks while smoking. It is now common professional practice to prohibit tobacco absolutely in all true or pseudo-anginal patients. Arteriosclerotics are forbidden its use. Neurasthenics are subject to high gastric acidity which is made worse by smoking. Many cases of nervous break-down in adults and adolescents can be traced to the too-free use of tobacco!

Speaking of indigestion, Thompson (Practical Dietetics) writes: "Undoubtedly most persons are better without it (tobacco), as its abuse is well known to disorder digestion through the action of nicotine on the circulation and especially on the vagus nerve. It is less likely to produce irritation if it is smoked while there is abundant food in the stomach. If there is any tendency to indigestion of starchy or saccharine foods, it is usually aggravated by tobacco in any form. Smoking before meals may destroy appetite and interfere with digestion of food."

S. Silbert (J. A. M. A., 89:964) reports 350 cases of thrombo-angiitis obliterans, and is convinced that prolonged smoking is the immediate cause; said that he had never seen the condition in a non-smoker. In the acute stages of syphilis, with mucus patches and irritable throat, it is almost impossible to heal the lesions if smoking is continued. Tuberculosis is the one disease in which smoking must be positively forbidden, because it aggravates cough, irritates mucous membranes and, usually, markedly increases discomfort. Acute and chronic rhinitis and sinus disease are hard to treat if the subjects are smokers. Goiters

are aggravated by tobacco and it should be avoided. Tobacco is such a toxic drug that it should never be administered internally or applied externally as a therapeutic agent except with the greatest precaution. Many research students have studied the possible sources of nicotine elimination from the body, but with no absolute conclusions. A recent editorial in the A. M. A. Journal (Vol. 98, p. 1657) states that a cigarette smoker who puffed away steadily for an hour might absorb as much as 36 mg. of nicotine if he inhaled; and 25.5 mg. if he only puffed—an amount sufficient to cause ill effects. It was found by Biebel, Essex and Mann (Mayo Foundation) that the liver is more active than the other organs in removing nicotine from the circulation.

With this rather rambling review of the literature on the action of tobacco and a partial understanding of its toxicity, one can readily figure its effects on adolescents. Prior to 1915, the medical profession and the laity were so thoroughly convinced of the evil effects of tobacco on growing children that laws were enacted and strictly enforced in most states against the sale and use of tobacco to minors. Some few of our Western states still enforce their laws and some prohibit the sale or use of cigarettes in the state by either adults or minors. Since the World War, conditions have changed. The medical profession has become absolutely negligent, and the laity convinced of the harmless character of the cigarette; instigated largely by the beautiful, artfully worded, glaring, lying, misleading advertisements in our daily papers and magazines and on bill-boards over the entire country. Thus, we have become a nation of smokers both adult and adolescent. Added to this debacle young girls and women have been urged to smoke cigarettes, by advertising appeals to their physical form and propaganda relating to their weight, beauty and attractiveness. Laws have been forgotten and the tobacco magnates have been allowed to run wild at the expense of the health of our rising generations. Hundreds of medical men have stooped to contribute their testimonials as to the harmlessness, or the desirability, of certain brands of cigarettes, without even stopping for a moment to consider the toxic effects of any tobacco, raw or specially-prepared, upon our American adolescents. As we are all familiar with the law of "survival of the fittest", let us, as medical men, stop and consider whether we are not to pay a penalty if we fail in our duty to the children.

Physical trainers in schools and colleges recognize tobacco as inimical to good physical sport. Those who train children for public speaking and singing, to maintain a clear voice must prohibit smoking. If tobacco is harmless, why does the profession prohibit its use to those with abnormal heart or lung conditions? Statistics are cited from many schools and colleges tending to show that the best work is done by the non-smokers. There are many exceptions to this conclusion, but most children who smoke become mentally heavy, nervous or irritable, and lack concentration unless temporarily stimulated by a cigarette. Many children have been brought to my office complaining of conditions referable to smoking.

In the presence of adenoids and infected tonsils, smoking causes great irritation and discomfort, and operations cannot be safely done until the cause of irritation, usually smoking, is removed and the acute inflammatory conditions have subsided. A goodly proportion of inhalers have a hacking cough that may, in time, become chronic, and which usually causes some impairment of vocal resonance. There are many individuals with disturbed heart action, extrasystoles, distant intermissions, slight tachycardia, and, in some, precordial pains. In the absence of focal infection or other acute conditions, some are found to be inhalers of cigarette smoke or users of a pipe; the undoubted source of their pathology. Most are cured by the withdrawal of tobacco. Tremors of the hands are quite common in girls and boys who are free smokers. If you will systematically examine the upper-chest of moderate or heavy inhalers of cigarette smoke you will, usually, find râles, mostly in the left fork near the clavicle level. It often becomes necessary, in dealing with girls who are strong smokers, to withdraw tobacco entirely, put them to bed and use some

sedative treatment, before their tobacco nervousness can be controlled; but be sure in these types to eliminate possible thyroid disturbances.

There is an ancient belief, among doctors as well as the laity, that smoking tobacco will, in the presence of contagion, give immunity. There is absolutely no evidence of the reliability of this statement and it should be repudiated. The old adage of not smoking until you reach your twenty-first birthday is a wise one. If the bodies of our growing children are kept free from the toxic effects of tobacco until development is completed, we will have a stronger, more stable, less nervous, and better class of manhood and womanhood. If, after that age, they begin smoking they are, at least, old enough to use some discretion. The average child does not appreciate this and usually goes to extremes and excesses unless vigorously restrained.

If tobacco has a toxic effect on the heart, and in our mind there is no doubt that it has, is it not possible that some portion of our great increase of heart affections may result from the increased use of tobacco? Any poison (tobacco is a narcotic poison) will gradually produce ultimate effects that appear in later life when the circulatory system is taxed by acute disease or over-exertion. It must be admitted that there are many exceptions among inveterate smokers who seem to suffer no ill effects, but these should not be used as examples to justify the abuse of tobacco, which, like opium, is a habit-forming drug. The medical profession has fallen for it, possibly to a greater extent than other professions, and for this reason, it has become negligent, and has over-looked the probable effects of smoking among adolescents and adults. We owe a duty to the nation's rising manhood and womanhood and, unless the medical profession becomes more active in curbing this growing habit among children, we will reap its pathology in adult life.

PROBLEMS CONFRONTING PLASTIC SURGERY

Chairman's Address*

Jacques W. Maliniak, M.D.,
Newark, N. J.

Although most of the major scientific acquisitions in the field of plastic surgery had been achieved and become common knowledge as long ago as the end of the last century, it was only within the past 2 decades that practice of this specialty made notable progress. As recently as 1925 there were yet no such specialized clinics or departments in the hospitals of New York and New Jersey.

Definition. We may say, considering its scope, that *plastic* and *reconstructive surgery* deals with the repair of congenital and acquired deformities with the aim of restoring function, with the exception of those involving the long bones, muscles and joints because these belong to orthopedic surgery.

From its beginning, during the Renaissance, until the middle of the nineteenth century (when Diffenbach published the first complete treatise on this specialty), plastic surgery was confined to the ear, nose and mouth, and this tendency to favor repair of *exposed* deformities has remained constant.

The first scientific treatise on plastic surgery was published by Tagliacozzi (1546-99), whose chief contribution was restoration of parts of the face with skin from the arm. The procedure is still used despite its rejection in 1742 by the French Academy of Medicine. The names of Carpue and Von Graefe were closely associated with the revival of plastic surgery in the beginning of the nineteenth century. Experimentation imparted a greater scientific value to the purely empiric methods previously employed. In this respect, the contributions of Diffenbach were of great importance, for with him plastic surgery extended its field to include *all* parts of the body.

The important problem of skin grafts was

*(Abstract of the Chairman's Address to the Society of Plastic and Reconstructive Surgery at its Annual Meeting in 1932.)

not solved until the appearance, in 1869, of Reverdin's publication on "Epidermic Grafts". Ollier, in 1872, described the use of large "dermo-epidermic grafts"; thus implying inclusion of the derma. In 1876, Julius Wolfe, of Glasgow, described for the first time his method of transplantation of full-thickness grafts, and he was the first to understand fully the factors involved in the "taking" of free grafts—the use of a skin of fine texture from the inside of the arm, thoroughly deprived of all subcutaneous tissue, and the necessity of pressure for the avoidance of "dead spaces" and the accumulation of serum under the graft. The use of small, deep grafts for covering large raw surfaces was originated by Schaede in 1877, and Thiersch, in 1886, published his experiences with large skin transplants thick enough to include the papillary layer of the derma; a fundamental method of skin grafting which is now half a century old.

Israel was the first (1896) to use a tibia graft in correction of saddle-back deformities, but in 1900 Von Mangold used a rib cartilage graft for the same purpose. *Thus, by the beginning of this century, the procedures applied today in grafting of bone, cartilage, and free or pedunculated skin flaps had already been fully developed.*

Lexer and Joseph in Germany, Gillies in England, Morestin in France, and Blair and Davis in this country, were intimately connected with the development of plastic surgery in the pre-war and post-war periods. It took the crying need for this work in alleviating war damages, to cut through all the stumbling blocks and place this specialty on a solid base from which it could develop rapidly. The situation provided a concentration of material, an invaluable opportunity to check up on the methods of the past and to explore the field thoroughly.

Present status. Advances during the past 20 years were motivated almost entirely by those who participated in the World War surgery. The chief reason for the slow dissemination of knowledge in this special work has been the *lack of scientific organization so essential to medical progress.* As practiced, by general surgeon or specialist, *without organized research facilities; without graduate and post-graduate education;* without an open forum for the free and honest exchange of ideas; *without journals sufficiently devoted to its interests;* plastic and reconstructive surgery progressed slowly, of course, and it now finds itself in the position of being deliberately ignored by large sections of the medical profession.

Cleft lip and cleft palate are the most important of all congenital deformities in infancy. There is no reason, with the technic at our disposal today, and an artistic understanding of regional anatomy, why any cleft lip repair should fail to effect a satisfactory reconstruction, but we have found the modified Thompson method the most satisfactory, because it is based upon reconstruction of the cleft by means of flaps of equal measurements to attain symmetry. In the case of cleft palate, the matter of function is paramount and closure should, therefore, be attempted at an early age. Of the many methods available, that of Veau is to be preferred because it utilizes the nasal mucous membrane, as well as the covering of the vomer, for reinforcement of the buccal mucoperiosteal flaps and permits the attainment of a palate having sufficient thickness and length and a great amount of mobility. There is still room for improvement, however, in this field.

Otoplasty. Among the other congenital deformities whose repair can stand improvement is the total loss of an ear. The difficulties encountered in rebuilding an auricle are due to its unusually irregular shape and intricate design. The procedure of choice should consist in the utilization of a *tubed skin flap* from the neck to provide the required covering for the auricle. The necessary support is provided by appropriately shaped cartilaginous grafts.

Skin defects. Reconstruction of facial defects by use of pedicle grafts from near or distant parts of the body, and free, split and full-thickness grafts, has recently attained great precision. Improvement is necessary in the closer matching of skin shades, and further improvements in art of tattooing would be valuable.

Burns present the most formidable problem in plastic repair. Early outlining of the

plan to be followed, with visualization of the various stages before the actual attempt, would spare unnecessary mutilations and save time. Early grafting of the burned surfaces precludes secondary infection and contractures; a great economic factor.

Proper immediate repair of torn and lacerated structures is of inestimable value in avoiding subsequent deformities. In this respect, we cannot over-emphasize the importance of a properly functioning plastic surgery clinic, in a general hospital, for the treatment of these emergencies.

Breast deformities. Women, especially younger ones suffering from breast deformities, are often seriously affected mentally. Discomfort, conspicuousness, and sometimes its handicap socially or professionally, serve to make the breast deformity psychically depressing to the patient. The procedure of choice consists in transposition of the areola, with removal of the excess tissue. In the giant type of hypertrophy, total mammectomy with free grafting of the areola is indicated. The many methods described are evidence of the lack of an ideal method offering a minimum of surgical risk and a maximum morphologic improvement.

Cosmetic disfigurements. The precise differentiation between cosmetic deformities and other types, is sometimes difficult because a cosmetic end-result is the aim in the repair of any deformity, at least on the exposed parts of the body. It is only natural that individuals with physical imperfections, especially of the face, should seek surgical relief. The 2 general groups are: hypersensitive adolescents; and, patients suffering from premature senility. *There is no doubt that many patients seek relief for the cosmetic effect; neurotic and hypersensitive individuals, particularly,* so, before attempting correction, one should always be certain of the indication for surgery. Generally speaking, the slighter the deformity, the more hesitant should the surgeon be, concerning repair, especially when the patient shows marked psychic instability.

Deformity and neurosis. This problem brings up the question of subjective and objective evaluation of the deformity. The greater the difference between them, the greater the possibilities of the presence of a psychoneurotic factor.

A deformity may manifest itself in the following ways: (1) As a function of personal value, considered from the esthetic point of view. (2) Where social values are at stake it may lead to neurosis. (3) It may be used to incite sympathy. (4) It may manifest itself as insanity. In all doubtful cases, a psychoneurotic examination prior to operation is imperative.

Medico-legal aspects. There are many medico-legal problems peculiar to this branch of surgery. Where health and life are at stake the surgeon is legally protected in the case of adverse complications. Because, in many instances, in plastic and reconstructive surgery protection of health and life is not clearly indicated, the plastic surgeon may not have the same legal protection. We feel, however, that a *conspicuous deformity,* because of its severe psychic reactions on the individual, and its possible influence economically, is as clear an indication as a club-foot or a fractured arm. The shock to the parents of a new-born infant, with however small defect, is well known to those who frequently encounter such things. A cleft lip, a minor deformity of the ear, a ptosed eyelid, all have the power to change the lives and outlook of *3 individuals,* the child and its parents.

There can be no indication for surgery where the deformity is inconspicuous or unimportant. Usually, the expectations of such patients are far higher than surgery can meet. In any event, the patient should be *advised in advance* what results may be expected. This will generally preclude much potential annoyance for surgeon or patient.

Conclusion. Plastic surgery is still in the formative period but there is every indication that unfounded prejudices in the profession have been broken down. Practitioners and laymen alike are increasingly realizing the need for a more concentrated effort in the treatment of congenital and acquired deformities. All must realize that repair of deformities should be left in the hands of those with the necessary skill and background; not only for the patient's best interests, but for the orderly scientific development of this specialty.

RETROPERITONEAL OR POSTPERITONEAL DERMOID CYST

Joseph C. Spallone, M.D.,
Newark, N. J.

Retroperitoneal or postperitoneal dermoid cysts are relatively uncommon; as a matter of fact, a brief survey of the literature does not reveal any such case but when they do occur, they usually originate in the subperitoneal connective tissue. We report a postperitoneal dermoid cyst which recently came under our observation at St. Michael's Hospital:

The patient was a young Italian woman, 24 years of age, whose previous history was essentially negative. She had been married 4 years and borne 3 children, all normal and by spontaneous deliveries. The last child was born 6 weeks prior to the time she came in for examination. Her chief complaints, which started 15 days after delivery of the last child, were pain in the rectum and a heavy, throbbing sensation, with tenesmus referred to the rectum. The pain was greatly exaggerated on defecation. She was becoming nervous and was unable to sleep at night. She noticed also an apparent purulent discharge from the rectum. There was no rectal bleeding.

A combined vaginal and rectal examination revealed a mass occupying the right side of the pelvis and the recto-uterine pouch of Douglas, which was smooth, tender, and fluctuating. Urinalysis was negative; leukocytes 7800; differential count of 56% polynuclears, 42% lymphocytes, and 2% eosinophiles.

She was sent to the hospital with a diagnosis of ischiorectal abscess. At the hospital she was examined by Drs. Harden and Leyenberger, who made a provisional diagnosis of pelvic abscess. Dr. E. J. Ill, called in consultation, aspirated the tumor mass through the vagina and obtained some light brown, rather thick fluid. Cholesterin crystals were found on microscopic examination of the fluid and, on that basis, he made the diagnosis of dermoid cyst of the right ovary.

It was decided to remove the tumor through an abdominal incision. On opening the abdomen, both tubes and ovaries presented a normal appearance. The uterus was retroflexed and the tumor was located in Douglas' pouch, retroperitoneally. It was fluctuating and pushed down on the pelvic fascia. The peritoneum over the tumor was incised and an attempt made to enucleate the tumor, but enucleation was possible only to the deeper portion of the tumor, stopping there because of fixation of the tumor to the pelvic fascia. In attempting to separate the tumor it was ruptured and its contents escaped into the abdominal cavity; whence it was removed by suction. From the vagina a rubber tube was inserted into the opening and an iodoform gauze drain was placed into the abdomen and the latter closed in the usual manner.

The patient had a very stormy postoperative crisis. She vomited daily, at intervals, a brownish fluid substance. There was no abdominal tenderness or distention; temperature rose to 103.4°; pulse barely perceptible, the rate being 162 immediately following the operation. Improvement, to some extent, followed on the third day, but on the fourth she had a relapse and died.

Discussion. The classification and nomenclature of dermoid cysts have long been a matter of debate. According to Graves, the modern view places dermoids and teratomas in one group called "Teratomas", and to conform to this view one should speak of cystic and solid teratomas. Popular scientific usage, however, persists in designating the cystic teratomas as dermoid cysts.

The origin of these tumors is still debatable. While many theories have evolved, none have been accepted by embryologists.

There are at the present time 2 main theories of histogenesis: (1) The Blastomere Theory, which states that such tumors have their origin in "wandering cells" that date back to the earliest cell division. (2) The Germ Cell Theory, which states that teratomas arise from sex cells of the ovaries. Graves states, also, that dermoid cysts are more common between the ages of greatest glandular activity of the individual.

It is evident, in view of the fact that the ovaries were normal in this patient, that this tumor probably arose from a "third or mis-

placed ovary", and Graves classifies such tumors as "true dermoid tridermal cysts, which may develop in the subperitoneal connective tissue. Further, Opitz and Menge say it is conceivable that from some irregularity of development and arrangement of the primary cells, a somatic blastomere (product of the first cell division) may become displaced and included, for example, in the ovary, where it may either be destroyed undeveloped, or, under the irritating influence of some chemical change in the blood or surrounding tissue substance, be awakened later from its dormant state to productive activity and create a dermoid cyst or a solid teratoma.

The cyst content is proteolytic and corrosive, and when discharged into the abdominal cavity is conducive to peritonitis. It is evident, therefore, that death in this case was caused by absorption of toxins from a pelvic peritonitis. No autopsy could be obtained.

APPLICATION OF THE BOLTZ TEST TO THE URINE

Robert A. Kilduffe, M.D.,
Director of Laboratories, Atlantic City Hospital,
Edna D. Wilson
and
Hilda Bernstein

Boltz, in 1923, described a color reaction occurring in the spinal fluid in dementia paralytica consequent upon the addition of acetic anhydride and sulphuric acid and due to the presence of an amino-acid, presumably tryptophan.

In 1930, Brice accidentally observed an occurrence of the reaction in urine and reported upon its incidence and possible significance as an evidence of renal disease in a series of 525 pathologic specimens. From a careful study of 167 normal controls Brice is convinced that the normal human being on an average diet does not eliminate amino-acid in the urine and that the Boltz reaction should, therefore, be consistently absent in health.

In the pathologic specimens, 35% of 161 medical cases, 33% of 332 surgical cases and 16% of obstetric cases gave a positive reaction.

When further segregated in accordance with the diagnosis, positive reactions were encountered in 72% of patients showing degenerative renal lesions, in 46% of those with acute infection, and in 42% of appendicitis patients. While, in the group of degenerative renal lesions albuminuria and a positive Boltz reaction were often coincident, this was not invariably so, because 16% of the positive reactions occurred in albumin-free specimens.

From this observation Brice suggests that the Boltz reaction applied to urine may prove of value as indicative of early or latent renal disease when found in albumin-free specimens. But 2 reagents are required, concentrated sulphuric acid, and acetic anhydride which should be a brand containing a relatively large amount of aldehyde. The technic is as follows:

(1) Filter, or centrifuge, the specimen and place 1 c.c. in a small test tube.

(2) Add from a pipette, a drop at a time, 0.3 c.c. of acetic anhydride, shaking gently after each addition.

(3) Add from a pipette, a drop at a time, and shaking gently after each addition, 0.8 c.c. of concentrated sulphuric acid.

(4) Allow the tube to stand at room temperature for 5 minutes and read.

The appearance of a light blue to deep purple color constitutes a positive reaction. When the reaction is weakly-positive, the color appears during the 5-minute period but is later obscured or obliterated by darker colors due to other unknown reacting substances; while strongly positive reactions may require dilution to distinguish the purple from browns or black.

The presence of bacterial growth, of an excess of phenol added as a preservative, or of formalin (1 c.c. per 10 c.c. of urine) destroys the substance producing the reaction. It is preserved, on the other hand, by the addition of chloroform, ether or phenol (avoid excess!), and may be precipitated and preserved by mercuric chloride.

In view of the results reported by Brice, the Boltz test was applied to a series of 400 unselected specimens of urine received in the

laboratory for "routine" urinalysis with the results summarized below.

Of the 400 specimens examined, 195 (48%) showed an albuminuria varying from less than 5 mgms. to 1800 mgms. per cent as determined by the quantitative method of Exton. Of the albuminous urines, 18 (9%) gave positive reactions the intensity of which, however, bore no relation to the degree of albuminuria. Of the 205 albumin-free urines, 17 (8%) presented positive Boltz reactions of varying grades of intensity.

In view of the variety of medical, surgical, pediatric, and obstetric conditions represented by the 400 specimens examined, the low incidence of positive reactions encountered suggests that a positive reaction may have some significance the nature of which, however, remains to be determined.

The low incidence of positive reactions in a relatively large number of patients presenting marked renal or cardiorenal lesions, suggests either that the Boltz test applied to the urine cannot be taken as reliable evidence of advanced renal disease or that the acetic anhydride used in this series was not suited to the purpose.

THE TREATMENT OF REPEATED STILL-BIRTHS AND MISCARRIAGES

Arthur W. Bingham, M.D.,
East Orange, N. J.

In presenting this subject for discussion, there will be a plea for more frequent administration of protiodide of mercury, illustrated by case histories.

Case 1. Special interest in this subject was aroused several years ago when a patient nearing full-term declared that she could not feel life, and the stethoscope revealed no fetal heart sounds. A still-birth resulted 3 days later, after a normal labor. This patient had a similar experience a few years before but the significance of it was not realized at the time. Wassermann tests on both, husband and wife, gave negative results. It was decided to give protiodide of mercury during the next pregnancy, and 2 years later, having given that drug throughout pregnancy, a healthy living baby was obtained.

Cases 2 and 3. Both patients had experienced 2 miscarriages and 2 still-births. Neither had a living child. Wassermann tests were negative in each case. After taking protiodide of mercury throughout pregnancy both gave birth to healthy living babies. One of these patients became pregnant again and, thinking she was all right, did not report until she had a miscarriage; having taken no protiodide.

Case 4. This patient was referred by another physician who said that she had given birth to 2 babies but both died just before easy births. He suggested that I do a cesarean section this time in an attempt to get the baby out alive. The physician was told that it would be better to give protiodide, as the trouble was probably with the baby and not a result of the labor. This was done and a healthy boy resulted. The mother was so delighted that she became pregnant again the following year, and then gave birth to a healthy girl; having taken protiodide of mercury throughout this pregnancy.

Case 5. Mrs. T. had 4 miscarriages in spite of every precaution. She was given protiodide before and during her following pregnancies; and has now borne 3 healthy children.

These case histories are sufficient to illustrate my point. I have prescribed protiodide of mercury for 101 women with negative Wassermann tests. In a few of these it may not have been necessary. In 1 instance it was a failure, and the patient continued to have babies which died after a few days; the deaths being, probably, due to some other cause; 2 patients had symptoms of salivation due to not following directions; 1 could not take the treatment at all, because it produced iodine poisoning.

The protiodide on the market varies considerably; some preparations being very irritating to the gastro-intestinal tract; given with charcoal in ¼ gr. pills, is the most satisfactory method. The average patient is given 1 pill twice daily—always after eating—for 3 weeks; then omit entirely for 1 week. If only 1 pill can be taken daily, on account of intestinal irri-

tation, it is given steadily with no omission. A few patients can take 2 pills daily, without omission, but there is then some danger of salivation, though 1 patient took 3 pills daily without any symptoms of poisoning. When given before pregnancy takes place, only 1 pill is necessary; increased to 2 during pregnancy.

Potassium iodide or Lugol's solution may be used in place of protiodide of mercury but, as some patients may require mercury as well as iodine, I have preferred the protiodide. It is also easier for the average patient to take.

There is very little on this subject in the literature. A recent writer advises doing a cesarean section or inducing labor in order to get the baby alive. This is a good procedure for a woman with nephritis, diabetes, or toxemia, but disappointing in cases of repeated still-births due to unknown causes; as the baby will then die soon after birth. It is better to treat the mother before and during pregnancy, and get a healthy baby delivered normally.

While this is a small subject, it is a very important one to those parents who have had no living children; and, if properly given, the treatment is simple and the results satisfactory.

Special Article

TESTIMONIAL DINNER TO DR. ARTHUR STERN

Russell A. Shirrefs, M.D., Reporter

A Testimonial Dinner was given to Arthur Stern, M.D., F.A.C.P., by his associates in the Elizabeth General Hospital and Dispensary on the evening of May 13, at the Winfield Scott Hotel, Elizabeth. It was a surprise affair to Dr. Stern, the arrangements having been kept secret until he was ushered into the presence of 73 of his medical friends who had gathered to celebrate with him his Sixty-Fifth Birthday. Following an elaborate menu, the Toastmaster, Dr. James S. Green, presented Dr. Charles H. Schlichter, who, after a pleasing address of reminiscence and felicitation, gave Dr. Stern a handsomely bound, hand-illumined, engrossed testimonial which was autographed by all present; and which read as follows:

"To Dr. Arthur Stern, Greetings:

The Medical Staff of the Elizabeth General Hospital and Dispensary present to you this Testimonial, as an expression of their very sincere appreciation of the valuable services which, for many years, you have rendered our Institution and those dependent upon its ministrations.

You have given unsparingly of your time, of your energy, of your skill, and of your thought, so that you have brought distinction to yourself, to our Institution and to the Science of Pediatrics of which we are proud to acclaim you as one of the leaders.

During the period between the beginning of your faithful service through your distinguished career as one of its Pediatricians, the Science of Pediatrics has advanced prodigiously, and you have, by deep study, the exercise of a keen intelligence and a deftness of skillful technic, given material aid to this progress; and also because of the life you have lived and the work you have done, much has been added for the greater good of humanity.

That you may long live to enjoy in retrospect the time you have spent in happy work and study is the wish of your associates and confrères of the Elizabeth General Hospital and Dispensary, whose regard is not alone of esteem for you as a scientist, but also one of affection for you as a man.

May 13, 1933."

Mr. J. N. S. Brewster, Jr., President of the Hospital Board of Managers, spoke in a happy vein, eulogizing Dr. Stern's long, faithful and efficient services as Pediatrist to the hospital. Many others, including Dr. Wells P. Eagleton, spoke of the love and esteem in which Dr. Stern is held by his large circle of lay friends and professional associates.

Interesting features of the evening were an original poem by Dr. I. Lerman, dedicated to Dr. Stern; and a topical song composed and sung by Dr. S. L. Haseltine. The happy occasion ended at a late hour, with all singing Auld Lang Syne.

THE APPROACHING ANNUAL MEETING

A Word from the Editor

This will be the 167th Annual Convention of this "ancient and honorable" body—the *oldest* medical society in the United States. Its status, on the score of age, is recognized by the medical organizations of other States, and that recognition is further supported by the Society's reputation for initiating new ideas and promoting the advancement of new projects. It has not infrequently been the starting point of measures designed to improve public health; and, it has also been watchful over the welfare of physicians and active in the starting, or in the support, of movements beneficial to the profession. It has never been an advocate of radicalism; nor, on the other hand, has it ever been ultra-conservative.

Among the chief items of interest to be considered this year, two are of exceptional importance.

(1) *"Medical Care for the American People"*, is the title given to the "Final Report of the Committee on the Costs of Medical Care", as published in book form. The January issue of your Journal was appropriately named—and it was printed on the front cover in red ink—the Special Economics Number—because it was devoted almost exclusively to the previously mentioned "Report" and matters pertaining thereto. We undertook, not as a matter of duty, but as a "labor of love", to strip that 200-page book of every word that could be spared, so that our readers might be served its essentials in compact form; and we succeeded in condensing what had been *an abstract* of the records, conclusions and recommendations, concerning a 5-year period of study of an important problem, into an abstract, 80 pages in length, which included all that any member required to put himself upon a level with those who constructed the recommendations referred to above.

To have given a copy of the "Report" as published in book form, to each of our members, would have cost approximately $4500. Supplying our members with the "essentials", in the manner described, cost the Society *nothing*. If the contents of the January Journal additional to the Abstract of that book, and the 15 pages of the April Journal dealing with the same economic problem, be combined with our abstract of that "Report", we may justly claim that our readers have been as well supplied as any group of physicians in this country with the available basic facts for use in the solution of the problem in hand.

(2) *Certification of Specialists.* At the last Annual Meeting, this State Society assumed leadership in this matter by adoption of the plan presented at the convention of 1930 by Dr. E. G. Waters. When the time came for putting the plan into effect, and the County Societies were invited to set up the necessary machinery, some criticisms arose, and in Hudson and Essex these were so pronounced that the State Society's Special Committee decided to suspend activities until this Annual Meeting, when the plan could, if desired, be submitted to reconsideration. There has been much talk in some regions about "killing" the proposition; improper methods in securing adoption of the plan have been imputed to its sponsors, and ulterior motives attributed to some who have spoken in its favor. Altogether, a ridiculous situation.

Suppose the plan, as adopted, is not perfect, is abolition our sole resource? May it not be amended?

In your April Journal, on page 366, the Dean of the College of Physicians and Surgeons, Columbia University, and Director of the Commission to Study Medical Education, Dr. Rappleye, expressed his envy that New Jersey had deprived his State, New York, of the honor of starting this movement; acknowledging that he had for several years been striving to secure that honor for his people. At the recent Annual Convention of State Society Secretaries and Editors, in Chicago, we were told that the A. M. A., having had this matter in hand for some time, was preparing to submit a plan shortly and to offer it for adoption by all the States. Public announcement has since been made concerning this general plan and its adaptation to certain specialties. Why should we not hold this attained honor of being *first* to do this thing, by making such alterations as may seem desirable or necessary? It seems foolish to throw it away because a few objectors do not like some of its features.

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive the paper will confer a favor by notifying the Chairman of the Publication Committee of the fact.

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THE NOBLEST ROMAN OF THEM ALL

William Gray Schauffler

"The Lord moves in a mysterious way his wonders to perform." Himself a firm believer, our colleague could not, and we know would not, have blamed us for skepticism, lacking any satisfactory answer to the question—why he, at the highest point of his always marvelous usefulness, should have been taken from our midst while so many of us who could immeasurably better have been spared, remain "to encumber the earth".

With permission we quote here from an editorial tribute (Princeton Herald, May 5), which was written by a Princetonian who prefers to remain anonymous:

"He saved others, himself he could not save."

"The community mourns the loss of a beloved physician. True to the traditions of his profession, he was responding to a call for aid when the hand of death struck him down. A fitting end to a life devoted to service. He died as he had lived, *ready*. * * * Modest in his skill in healing, unassuming in his profound knowledge and wide experience, generous in his praise of others, he was held in universal esteem, and it is not too much to say of him that he went about doing good."

From another editorial, though in the same publication, we quote an estimation of the man, in form about as we should have given it expression:

"Dr. Schauffler did not know what *self*-interest was. The matter of the moment always gained his intense concentration whether it was the relieving of a patient suffering from human ills or the furthering of an organization devoted to those noble ideals which he cherished. Virtue, to him, was its own reward. The satisfaction of having done his work well was more precious to him than money and in many cases it was the only return for which he asked.

Not to be served but *to serve* was Schauffler's rule of life. Primarily a physician, he extended his passion—*to cure*—to broader fields than that of medicine. He was a leader always in every movement for civic betterment. He was a leader always in every patriotic movement. A steadfast defender of what was good and right, he was an untiring warrior in the constant struggle against physical, social and political ills."

Our editorial plans for this issue of the Journal had been different—far different—but if, by limiting ourself to this single item, we succeed in focusing the attention of even one reader and causing him to emulate the example established by our just-departed friend and beloved brother—Schauffler—our own life will not have been lived entirely in vain.

Medical Ethics

A LESSON IN ETHICS FROM THE DRUGGISTS

John Hammond Bradshaw, M.D., F.A.C.S.,
Orange, N. J.

Although most of the physicians in the State may read the New Jersey Journal of Pharmacy, there are many things in the March issue that can well bear repetition. Especially noteworthy is the message entitled *"Plain Talk on a Serious Subject"*. Although dealing mostly with economics, there is a deep underlying ethical thought running through this important article.

"One of the causes of the high cost of medicines is the great multiplication of proprietary specialties. The practice of prescribing high priced proprietary medicines has reached such proportions as to increase the pharmacist's investment and carrying charges to prohibitive figures. * * * Have you ever looked at the 'Dig'—section of the prescription shelves of a pharmacy which specializes in prescription work? If you have, you encountered among others the following: 'Digitan', 'Digital', 'Digatin', 'Digafolin', 'Digitaligen', 'Digataline', 'Digitalis Dispert', 'Digitax', 'Digifortis', 'Digigluten', and 'Digitalone', to say nothing of 'Digitalis Leaves Upsher Smith', 'Digitalis Leaves Lederle', 'Digitol', 'Purified Tincture Digitalis', and so *ad infinitum.*"

Now, this is not written with the purpose of knocking any pharmaceutical corporation or company. Remember, please, that this quotation is taken bodily from a pharmaceutical journal. It would never have been written, in the first place, if the druggists themselves had not considered the subject an abomination. Ethics and morality cannot be divorced. Did not Webster tell us that "morality is the doctrine of human duty"? Now, if it is not the duty of physicians to aid their patients, particularly in these hard times, in every way, and to aid their best friends, the druggists, so that by cutting down their "overhead" they can make their charges moderate to those who are sick and suffering, and, selfishly speaking, to avoid clogging their own brains with an unnecessary burden of many names for numerous almost identical drugs, then the writer will acknowledge that he has made a mistake in writing this paper.

Collateral Reading

A DOCTOR'S ADVICE TO HIS CRITICS

For several years past the medical profession has been subjected to criticism of varied sorts and by an unusual aggregation of critics, using mostly the popular magazines as the medium for publication of their grouches and complaints. For the most part, physicians have paid little attention to such articles believing, probably, that magazine readers would not be seriously influenced thereby; would not become antagonistic, at any rate, to a profession some member of which had been present to usher them into this world, and had been in readiness at all times since to render aid in what-so-ever manner might be required in the fields of preventive or of curative medicine. Rarely, some physician or some kindly disposed, still-grateful, former patient has taken up the cudgels in our defense, and it is one of those direct answers by a physician, written anonymously, we have chosen to call to your attention this month.

In the recently combined Forum-Century Magazine, of June 1932, under the title—"A Doctor's Advice to His Critics"—a member of the medical profession gives "a piece of his mind" to those who have been indulging themselves in the youthful prank of throwing stones. The article is in form different from what we should have chosen, and is, in fact, decidedly different from the form used in another article—"What About Lawyers?"—a portion of which we republished, but it may be that it is *this factor of variation* which accounts for its acceptability. So, we shall present an abstract, of sufficient length to cover all the essential features, for those who may not have seen the original publication; what follows constituting a re-arrangement of selected, disconnected paragraphs, and it may be well to say that we do not concur in some of the statements made.

I am a doctor, a regular M.D., a practitioner of medicine. My net income is about $3000 a year. I manage somehow to read a little, including a few magazines occasionally. In them I note many more or less violent assaults on the medical profession and much indignation about its clumsy bungling, inadequacy, and general swinishness. These things never bother an actual doctor at all; he is used to that; he just goes on and takes it as a part of the day's work. But it might be interesting to a layman to hear a suggestion or so from the other side.

Take the Editor of The Forum, for instance, obviously and surely a high class man. He says that the practice of medicine is supposed to be a science. Well, if it is, that is news to me: I never heard that before. He states this simply and easily as he would an axiom, and yet he is utterly wrong in his first and fundamental premise. The practice of medicine is not a science, never has been, and I doubt if it ever will be. Man will have to push the unknown clear off the map and make vicious inroads into the unknowable before this can be.

At its best, the practice of medicine is an art, though it presupposes certain kinds of knowledge, just as an architect must know his mathematics. A surgeon knitting his brow over what to do after he is in an abdomen is not primarily a scientist; he needs far more than that. Many are the times that I have sat by the bed of a patient, after I had got all the data I could, and had *feelings* about him—feelings as to the nature of his illness, the probable outcome, and the best course to take in treatment. And I act on this, though for the life of me I could not tell you just why. This is not science; by no flight of the imagination could it be reduced to a formula or an equation. The variable factors are infinite. Please remember that medicine, more than anything else in the world, deals with the ills and maladjustments of human beings, and the human being is the most staggeringly complicated and incredibly intricate piece of machinery that the Lord God Almighty has ever concocted.

Now this feeling—call it instinct or intuition or what not—is, I believe, nothing more than accumulated experience, the details of which have sunk into the unconscious and there undergone some arranging and crystallizing so as to color and affect the conscious work. Surely this must be the case with the ordinary man, but I sometimes think that maybe in a man like Pasteur it might have been not quite so passive but more dynamic and directional. He had a sort of genius for moving about in a realm where neither he nor any other man previously had any experience. He could map out the lay of the land even when it was so foggy he could not see. Anyway, the lives of men like him may lend a little color to the idea that there are valid ways of getting what we call knowledge without invoking the scientific method. I cannot say, of course; maybe he was just extraordinarily lucky. At any rate that is not *science* as I understand it. But it is what we have to use.

No Man's Land

The next misconception is a shocking ignorance of the *limitations* of medicine—in the present state of human knowledge and in the present state of economic and social order. You see there are 2 horns to this bull, and we will take the left one first. You ask of us the impossible and get irritated when we cannot deliver, but you apparently never look about you. Don't doctors get sick and suffer and die just like anybody else? Don't their own parents and brothers and sweethearts and wives and their own little children die just like yours? As a matter of cold statistics doctors die a little earlier than most men. Don't we all have our share of trouble about the same, and don't we all go down the chute to death, king and commoner alike, just about the same? Why don't we change all this? Aren't we doctors? Answer: we cannot; we don't know how.

The Advance of Science

From this you may conclude that medicine is in a medieval condition. But you are wrong again. As a matter of fact, medicine is making astounding progress, and I would hesitate to set any limit to what may ultimately be accomplished, and I base this statement not on mere hope but on the actual record of solid achievement in the past. Indeed the barrage is lifting so fast that the trudging infantry actually cannot keep up with it. My great-great-grandfather was a doctor of a sort but he never went to a medical school. He "read" medicine, and in addition to his doctoring he was also a blacksmith and wheelwright; he bled people and pulled teeth. My great-grandfather was a doctor and graduated from a Class A school in 1821. He bled and he blistered and he puked and he purged—and this was about his armamentarium. He prepared his own crude drugs. He carried his catheters in the sweat-band of his high hat. He didn't even have ether or chloroform.

My grandfather was a doctor and graduated from a Class A school in 1857. Bacteria were unknown; pus in a wound was considered laudable. His appendicitis patients died of "cramp colic" and "locked bowels". He didn't even know that tuberculosis was communicable. He did not have a hypodermic syringe nor a fever thermometer. Operations were mostly amputations. The insane were shamefully treated and almost regarded as bewitched.

My father was a doctor and graduated from a Class A school in 1884. Diphtheria was rampant and deadly, and so was typhoid fever. He didn't have diphtheria antitoxin nor

typhoid vaccines; nor serum for meningitis or tetanus or poliomyelitis or pneumonia; nor thyroid extract nor adrenalin nor pituitrin. Blood transfusion was unknown. Lumbar puncture had never been done.

I am a doctor and graduated from a Class A school in 1920. I did not even have insulin for diabetes, nor liver extract for pernicious anemia, nor scarlet fever serum, nor erysipelas serum, nor the malarial treatment for paresis.

Patients Who Won't Be Cured

I said above that even if the doctors knew the exact diagnosis and the proper treatment they might still be helpless. This is the precise condition that doctors have to contend with all the time. Every day my hands are tied and I am reduced to impotence by things over which I have no control. In the first place, the doctor cannot make the patient do anything. He advises operation, say; the patient refuses. What can he do? Answer; nothing. When the patient dies, however, he has "lost" the patient; he was a bum doctor. Patients will not follow a prescribed diet; they will not even take their medicines; they will not come regularly for their treatments; not infrequently they pay no attention whatever to any advice given them; they will not quit work and go to bed; they will not leave home and go to the hospital; they will not allow tests; they object to adequate examination; they resent questioning; they lie, in giving histories; they are impatient and fussy and stupid and ignorant and non-coöperative. Not all patients; no, of course not. But such a large percentage that many bright and honest doctors simply cannot endure the farce and quit the whole business in disgust. There are a lot of Martin Arrowsmiths in this country.

But that is only the beginning of the trouble. Granting that the patient is a perfect patient, can he pay for proper care and treatment? In a shocking proportion of cases the answer is: no, he cannot. The simple fact is that as medicine has become better and more extensive in diagnosis and treatment it has become more expensive. As it enlists more appliances and better facilities, more people and better people, the cost increases. This has gone on till it has become unbearable to people of small or even moderate means—if they want the best that can be had. My great-grandfather's patient with an acute appendix probably stayed at home and got a purgative and a mustard plaster and such simple remedies, which cost him little or nothing—except his life. My patient is taken to a hospital and operated on and nursed and restored to health —for perhaps $200. In one case he pays his life; in the other he pays $200. Which is better? But suppose he does not have $200 or even $2. What is he to do? God only knows; I don't. I have sweat blood over that question many a time and I still do not know the answer, but I suspect it and will give it to you later.

The hospital to which he goes costs money. It was built by union labor at so much per hour. Its furnishings cost money. Electric companies do not give away x-ray machines; they sell them for money. Pharmaceutic houses do not give away medicines; they sell them for cash money. Lights, heat, gas, laundry, phones cost money. The cook works there for exactly the same reason a cook works in a hotel—for money. So do the maids, fireman, elevator man, janitor, stenographer, telephone operator, bookkeeper, and all the rest. For every loaf of bread or can of beans that goes in there the grocer demands money. Then there is insurance, upkeep, taxes—what not. The graduate nurse who cares for him has spent 3 years working for nothing before she got her license. She has rent and other expenses to pay; she has to buy food and clothes. She may soothe the fevered brow, and all that sort of rot, but she cannot live on that. She has to have money to pay her bills. And so it goes. About the only thing the hospital gets for nothing is the flowers sent there after somebody's funeral. It is a simple matter of bookkeeping. Where is this money coming from if not from the patients?

It is outrageous that a sick man should be turned away from a hospital simply because he has no money. But is there anything unique in this? Aren't hungry people turned away from restaurants? Aren't ragged people turned away from clothing stores? Aren't shelterless people turned away from hotels? Aren't foot-sore and weary people turned away from bus stations? It is outrageous that I should refuse to treat some people and only half-treat others, but what else can I do? The average ordinary doctor can no more furnish and provide modern and adequate care for his patients than a railroad engineer can provide the locomotive that he drives.

I doubt if a Harvard Medical School graduate put out in the backwoods could actually use 10% of his knowledge. A great hullabaloo has been raised about the disappearance of doctors from isolated and country districts. Nothing whatever can be done about it. What does this mean?

It means that this whole thing is *not* a medi-

cal problem; it is a *social* and *economic* problem. The solution will come through some form of *state medicine*. This word is anathema, of course, to all right-thinking doctors; it is the red flag at which every Medical Society is supposed to lower its head, hoist its tail, and charge. But there isn't much steam in the charge; it is mostly a gesture, a futile one at that. There was once a king named Canute who did the same thing to the incoming tide. For better or for worse, it is coming and coming fast. Most doctors would probably be far better off on a decent salary anyway; and 50 years from now, I believe, a majority of them will be on salary. There will always be private doctors and private hospitals, of course, for people who want them; just as there are private schools and private tutors for certain children. But most children go to the public schools; and most poor sick people in the future will go to public hospitals supported by taxation.

Do Doctors Give Good Service?

Now suppose the patient has plenty of money; is a perfect patient, and is not neurotic. Does he get good service? The answer is: *in general, yes!* But why "in general"? Because doctors, on the whole, are not particularly different from other men of their social and economic level. There is nothing special in his training that changes his make-up; if he is a cad before he studies medicine, he is generally a cad after he studies it. Furthermore, no matter how honest, they make mistakes. So do engineers. So do soldiers. So do merchants. So do bankers. What about the veteran financiers who supported Anaconda Copper at 117 (quoted today at 9)? It is a merely human quality.

It is more or less accidental that your banker is not your doctor and your doctor your banker, or even your chauffeur or your plumber. One of the best doctors I ever saw was a plasterer and a lather for some years before he decided to study medicine. Perhaps the greatest brain surgeon in this country today was formerly a railroad mechanic and his father a locomotive engineer. There is no presiding destiny that picks certain men to be doctors; it is largely a question of suggestion and opportunity and the necessary finances.

Some of the scurviest and most ignorant jackasses I ever saw, and some of the damnedest swine I ever met, were doctors in active practice. There is nothing surprising or unexpected in this. But I can say, also: that on the whole, they are an honest, competent, and resourceful set of men at their trades, and that most of the difficulty comes from expecting too much of them. It is preposterous to think that 150,000 men selected more or less at random, should be scientists and artists. They are not. The average doctor is a trailer, a camp-follower, a nonentity, who contributes nothing to medical science but merely tries, according to his lights and opportunities, to apply what other men have discovered.

On the whole they are not, however, a bad set of men. I know of no men who work harder to put themsevles out of business. The medical profession has waged relentless war to prevent disease and improve public health. Be it noted, in passing, that in this they have fought almost single-handed and have often found it necessary to put such measures into effect *against the determined and even violent resistance* of the very people they were trying to help. If you do not believe this then go read the history of the struggle for compulsory vaccination, the segregation of communicable diseases, the sanitary disposal of sewage and waste, and a hundred other such things.

Why They Study Medicine

There is, finally, one other reason why the service is good only "in general" and that is the fact that doctors are under the necessity of making a living for themselves and their families. This is a trite enough observation, but, believe it or not, it is quite often ignored by the critics. You see we are still impaled on that bull's right horn—the social and economic order. Medicine is so old and has been swathed in so much hocus-pocus (aided and fostered by the profession itself) that only a man who has cut his eye teeth can see through the bosh to the truth at the heart of the thing.

One familiar delusion is to the effect that doctors are animated by an old saying, to wit, "the relief of suffering humanity shall be thine only aim". This is a piece of poppycock that is not true and never was true. The cold fact is that most doctors practice medicine for precisely and exactly the same reason that lawyers practice law, or editors edit, or plumbers plumb, or laborers labor—namely, to make a living. If they get some pleasure out of it and do some good, then so much the better, but that is not the prime purpose.

It may be deplorable, but it is a fact, that *this thing we call civilization*, or this present state of human affairs, is just simply not organized along the lines of brotherly love. For all the boloney to the contrary, it is founded largely on the ethics of the jungle, and it is the persistence of this jungle ethics in a highly

complicated and interdependent society that has finally plunged us into the morass in which we are now stuck. Doctors have been merely in the same milieu as everybody else. Doctors find out, as all men do. that they get what they take. This leads to dishonesty, sharp practice, swinishness. I can only report that doctors as a rule are as honest as circumstances will allow them to be. I do not care to speak further than that for them.

But I can speak for myself. Here at least I will pass no buck; I will evade no issue. It all boils down to this: a man catapulted into this life and given time to get oriented and look about a bit can do one of two things—he can take it or leave it. I prefer to take it. Very well, then, what do I find? I find that this is a hard and a harsh world. I find that my living depends entirely on my own efforts. I find that I could sweat out my life in honest and conscientious medical service to the public for nothing save a bare existence and finally come to 65 or 70 a broken and penniless old man. I find that in exchange for this they would, if I had enough political pull, give me a cot in a poorhouse, some rags, enough food to keep me alive, and the menial job of scrubbing the floors.

Now, I prefer not to stand in breadlines nor to sleep in flophouses. I must, therefore, get money in some way or other and endeavor to keep it. It has been amply demonstrated that this latter task is perhaps even harder than the first; I have no assurance that what I have now will be with me next year or even next week. The method I have chosen, by which to do this, is practicing medicine. I went through high school; I spent 5 years in a university, 4 years in a medical school, 2 years as a hospital intern—15 years in all. I not only made little or nothing during this time but I spent a great deal; in fact, all I had ever been able to make at other times. In addition to that, I put a lien, in the form of debts, on what I was to make after I finally went to work. Now that I am at work, I will get that needed money absolutely honestly if I can. If I cannot, then I must get it dishonestly. There, then, you have it—in cold type and with no evasion. If this is being a thug, then I am a thug. And that is that. If you are interested to know what has been my experience, I will say that the word honesty in medicine is a very *elastic* term. But I am in style, to say the least, for this is rugged *individualism*—now officially inscribed on the banners of the Republic.

Current Events

WELFARE COMMITTEE MEETING

Trenton, N. J., April 23, 1933

Pursuant to a call regularly issued, the Welfare Committee met in the Princeton Room of the Stacy-Trent Hotel, at 2 p. m., April 23. Roll call showed the following members and guests present: Berkow, Bloom, Clayton, A. H. Coleman, J. G. Coleman, Conaway, Costello, Dandois, Davis, Green, Hagerty, Haggerty, Haussling, Larkey, Lee, Lippincott, Londrigan, McBride, McMahon, Morrison, Morrow, North, Schlichter, Sewall, Sherman, Sommer, Tracy, Ulmer, Quigley, Newcomb, McGuire, Mahaffey, Councilors Beling, Snedecor, Scammell and Fischer, and Dr. Fischelis, of the Pharmaceutical Association. Excuses were received from Drs. Donohoe, Mulford and Schauffler.

The Executive Secretary's Report, having been called for, was read as follows:

April 23, 1933.

Report of the Executive Secretary to the Welfare Committee

With the General Assembly of New Jersey still in session, and each week noting the introduction of additional Bills, it is impossible to predict, with any degree of safety, what will happen to us from that source ere adjournment be taken. Thus far, there have been 352 Senate and 484 Assembly Bills introduced, along with 23 Senate, and 12 Assembly Joint Resolutions; a total of 836 Bills and 35 Resolutions, or a grand total of 871 pieces of legislation proposed.

Even medical Bills continue to appear, and we have to report the following as having been presented since our meeting in March.

S. 312, a vicious effort to open widely a passageway for the holders of limited licenses into possession of the full rights and privileges of the Medical Practice Act.

S. 313 would grant the optometrist license, without examination or other qualification than "residence in New Jersey for 30 years and possession of an optometry license from some other State"; evidently designed to apply to some one individual whose tale of woe appealed to Senator Young.

A. 401, introduced by Mr. King, also of Morris County, is apparently intended to provide for liens, in favor of physicians, on awards in accident cases. Dr. Londrigan and I agreed that it seemed best for the time being, at least, to emulate "Brer Rabbit"—and lay low. We would like to know, however, if anyone present can tell us from whence it comes.

As to the status of Bills previously reported, we may say:

Assembly Bills: 144, 145, 146, introduced by Dr. Newcomb; 171, to raise educational standards for Chiropodists; 188 requiring hospitals to open their accident case records to attorneys; 214, Dr. Mutchler's pre-school child health examinations; 327, concerning Naturopathy; all have been consigned to the Morgue.

A. 374, passed in the Assembly April 11, is now in the Senate Committee on Public Health, Mr. Leap, Chairman.

Senate Bills: S. 125, amended by addition of the objectionable feature transferred from S. 126, is still in committee.

S. 221, on Expert Testimony; and S. 226, on Osteoptahy, are quiescent.

S. 229, the so-called Uniform State Narcotic Law, has passed the Senate and appears to be scheduled for passage in the Assembly. With relation to this Bill, it should be explained that since our meeting in March, when this Committee voted against S. 229 in its then amended form, further changes were made in it. Having learned that, whether we liked it or not, the Bill was listed for passage; and having received from Dr. Woodward, representing the A. M. A., an appeal to support the Uniform State Law on Narcotics, which S. 229 purported to be, a special meeting was called by Health Director Mahaffey, who invited to his office representatives from all groups and organizations interested in this matter; Mr. Merck, manufacturer; Mr. Fischelis, pharmacist; Dr. Steigerwald, dentist; Drs. Lippincott, Morrison and Reik, physicians; etc., and Commissioner Anslinger, from the National Bureau of Narcotics, came up from Washington to explain what was desired by the National Government and had been agreed to by the A. M. A. The result of that Conference, attained by a smaller committee selected from among those present, changed the appearance of things materially, and the Bill, as it will be passed, is probably the best obtainable at present, and certainly better than what we would have received had we failed to meet the conditions which arose after this body had spoken; an instance, perhaps, where "the end justifies the means".

But one other Bill remains for consideration—S. 351—introduced on behalf of the pharmacists, and Dr. Fischelis has promised to give you an explanation, when asking for our support.

Respectfully submitted,

Henry O. Reik, M.D.,

Editor and Executive Secretary.

Upon motion of Dr. Morrison, the report was received and adopted.

Taking up the legislative Bills separately: S. 312, S. 313 were opposed and the Executive Secretary and the Special Legislative Committee received instructions to try to prevent the passage of such Bills. Regarding A. 401, the Executive Secretary's action was approved.

Reference having been made to S. 229, the Executive Secretary explained how the Bill came to be reconsidered after the action taken by the Welfare Committee stopping negotiations. The actions taken by Drs. Mahaffey and Reik, and later by the Special Conference Committee, were approved.

At the request of the Executive Secretary, S. 351, introduced on behalf of the Pharmaceutical Association, was explained by Mr. Fischelis; and the Welfare Committee approved the Bill and the giving of assistance toward its passage.

Dr. Quigley, Chairman of a Special Committee (consisting of himself and Drs. Green and Morrison) appointed by the Board of Trustees, explained a communication received from Colonel J. H. Bigley, Manager of the State Emergency Relief Administration.

IMPORTANT MEMORANDUM

Re-Proposals to partially compensate physicians for services to E. R. A. clients.

To—Welfare Committee.

From—Committee, Board of Trustees, (F. J. Quigley, J. S. Green, J. B. Morrison).

The proposals involve a radical departure from the traditional principles of the profession, heretofore controlling, in the care of individuals unable to pay for medical service. The subject should command most careful consideration, for while such a change of policy may be justified as a temporary expedient made necessary by reason of the severity and prolonged extent of the present emergency, serious thought should be given to the possible permanent end-results of the establishment of the plan now proposed.

If this scheme is adopted by organized medicine, it should be with full realization that, for the time being, we are accepting *State Medicine* in its fullest sense, as applying, at least, to a large portion of the population.

The other side of the picture is: that these proposals, emanating as they do from the State Emergency Relief Administration, recognize the tremendous load the profession has been carrying for 3 years and the enormous monetary contribution it has made to the State in treating, *gratis,* the unprecedented number of its citizens unable to pay for medical care.

Incomes of the vast majority of physicians of the State have sharply and steadily declined, many almost to the vanishing point. Almost every community contains physicians, not all young in practice, unable to meet necessary current expenses, yet giving freely of the only commodity they have to sell to maintain a livelihood: medical knowledge and service.

Determination should first be made, as to whether the Society will accept in *principle* the proposals of the Emergency Relief Administration. Final decision should be made only after ascertaining the wishes of the entire membership. The matter should be comprehensively presented to each Component Society, promptly at a regular or special meeting, if possible within 2 weeks. If the plan is to be adopted, unnecessary delay means the loss of thousands of dollars to the physicians of the State.

If the proposed plan is put into effect, the Society should clearly state that it accepts this as a temporary policy, only, made necessary by the severity and length of the emergency, and that it shall cease immediately upon termination of the emergency.

We recommend that the Councilors shall: (1) bring this matter to the attention of all Component County Societies; (2) and in the event that the proposals of the Emergency Relief Administration are adopted in principle, that a special committee of the Society consisting of the President of State Society, Chairman of Board of Trustees, Chairman of the Welfare Committee, the Councilors and Drs. Quigley, Morrison and Green be created to work out with the Emergency Relief Administration a mutually satisfactory plan and method of operation; (3) this committee shall determine when the emergency shall cease to exist; (4) the policies and the operators of this plan, both by the State and Counties, at all times, shall be directed and controlled by accredited representatives of the Medical Society of New Jersey. Approval of the plan shall be conditioned upon the acceptance of this principle.

Colonel Bigley, in a letter addressed to President Lippincott, described the plan being used for relief of those in distress, and asked for coöperation on the part of the Medical Society of New Jersey. His letter was mimeographed and a copy there-of sent by the Executive Secretary to each member of this Welfare Committee and to each Councilor.

Dr. A. Haines Lippincott,
President, Medical Society of New Jersey,
Camden, New Jersey.

Dear Dr. Lippincott:

The State Emergency Relief Administration is desirous of receiving the coöperation of your Society. It is our feeling that the following important points should be discussed:

(1) Establishment of a uniform procedure of authorizing medical care to Emergency Relief Administration's clients in various towns throughout the State.

(2) During this emergency there is an increasing need of medical care and a need of a large number of physicians to take care of this increasing load.

(3) Establishment of a uniform fee for home visits and office visits.

(4) Establishment of a uniform fee for special visits.

(5) Procedure for rendering bills for services given to relief cases.

(6) The use of National Formularies or U. S. Pharmacopeia in issuing prescriptions for Relief Cases.

(7) The appointment of a State Committee to be advisory to the State Emergency Relief Administration.

(8) Appointment of committees by County Societies to coöperate with county and local municipal relief administrations.

It is our suggestion that your Society appoint a committee to meet with this Administration with a view of discussing the above 8 points and endeavor to arrive at an equitable basis of operation.

If you will be so good as to advise the undersigned when it would be convenient for such a committee to meet with him, it will be greatly appreciated.

Yours very truly,
(Signed) J. H. Bigley,

State Manager, Dept. of Work Relief, of the New Jersey State Emergency Relief Administration.

After Dr. Quigley had explained Colonel Bigley's communication, it was presented for discussion.

Dr. Morrison said that this will be the first time such a policy has been employed by this Society. He referred to the "Iowa Plan" and the "Suffolk County Plan" as being similar for dealing with the indigent sick. He stated further that, as Dr. Quigley had previously said, there is in it an element of danger, in that, if employed successfully, it may stir up those who believe in a wider type of State Medicine.

Dr. Schlichter asked if he had correctly understood Colonel Bigley to say that his organization had already been paying physicians for this kind of work.

Dr. Quigley verified the statement, and added that, until recently, he had not known that work of this kind was being done and paid for anywhere in New Jersey, but that he had recently been informed that the Bergen County physicians are familiar with it, and that Dr. Snedecor, present as one of the District Councilors, could explain that situation.

Dr. Snedecor welcomed the opportunity to offer such an explanation and stated that the Hospital Association of New Jersey had established such a relationship with the Relief Committee, and when that fact became known, the Bergen County Medical Society entered into negotiations with the County Relief Committee. The County Society had notified the Relief Committee that the physicians felt that it was their duty to look after the indigent sick and that there was no necessity for opening clinics because such indigents could as well be sent to their family physicians or to existing hospitals. That was arranged and the plan worked satisfactorily for a short time, with the *County* Relief Committee; for, it was only recently they had come in contact with the *State* Relief Administration. He stated that the chief difficulty the County Society had encountered was with its own members, some of whom failed to respond promptly or properly to the medical work directed to them. The hospitals had, however, soon become unable to bear the burden, and the Relief Committee has promised financial assistance to the hospitals, the nurses, and even the midwives. The County Society had recently drawn up a different plan and, out of his experience, he discussed several important points. For instance, he thought it unwise to permit the Relief Administration to establish clinics and to pay the physicians connected with such clinics. One point of interest was the necessity for making specific arrangements as to who should have authority to send such patients to physicians and whether such authorization to treat indicated patients should be in writing. He referred also to the fees allowed for home or hospital visits, for office practice, and for obstetrics.

After considerable discussion, in which Drs. Quigley, Snedecor, Newcomb, Hagerty, Schlichter, Haussling, Lee, Clayton and Morrison participated, resolutions were adopted as follows:

Dr. Morrison moved that "the Welfare Committee *approves in principle* the plan proposed by the State Emergency Relief Administration", and his motion was adopted.

Dr. Morrison moved further that "the Welfare Committee *approves in principle this plan of caring for the indigent sick*", and his motion was adopted.

Dr. Morrison further moved that the committee appointed by the Board of Trustees should be enlarged, as suggested by Dr. Quigley, so that it would be a Continuing Committee composed of, in addition to those mentioned, the Councilors, the Officers of the State Society, the Chairman of the Board of Trustees, and Chairman of the Welfare Committee, and that this enlarged Committee shall determine when this *emergency plan* of rendering medical service shall cease to exist, in so far as the State Medical Society is concerned.

Upon the conclusion of this discussion and supporting action, the above mentioned enlarged committee retired to a separate room to work out a plan of procedure for rapid action throughout the State; each Councilor to call the County Societies in his District into special meetings, to be held as soon as possible, for this purpose.

Dr. Londrigan reported that the Committee to Confer with Hospital Representatives, of which he was Chairman, through Dr. Keller, has not accomplished much as yet because of the illness of Dr. Keller.

Dr. Lippincott requested that the Society extend an invitation to the New Jersey Homeopathic Medical Association to coöperate with us in this emergency work.

Dr. McGuire brought up a question of concern to physicians licensed to practice medicine by the law of 1880, and stated that the Attorney-General wished to know if the Medical Society would ap-

prove an amendment to that law which would enable the State Board of Medical Examiners to license and *to revoke licenses* of physicians registered under that law.

Upon motion of Dr. Davis, it was voted that authorization be given favoring the introduction and passage of such an amendment.

Dr. Sherman presented a written report for the Committee appointed to study the "Final Report of the Committee on the Costs of Medical Care", and he was requested to further develop his report, as he might see fit, and present it to the House of Delegates at the Annual Meeting of the State Society.

Dr. Fisher, Councilor for the Fourth District, read a "form letter" prepared by the enlarged Emergency Relief Committee to be sent all County Society Secretaries; which letter was approved by unanimous vote, and reads as follows:

Dear Doctor: On April 23, 1933, a meeting of the Welfare Committee of the Medical Society of New Jersey was held in Trenton to consider proposals of the State Emergency Relief Administration to compensate the Medical Profession for the medical care of Emergency Relief Administration's clients.

A Special Committee appointed by the Board of Trustees, with power to act, has been designated to formulate a policy and plan for medical relief mutually agreeable to the profession and Emergency Relief Administration. This committee has approved the *principle*—of compensation to physicians by the Emergecy Relief Administration—during the emergency *only*. A copy of the resolutions approved by both the Welfare Committee and this Committee is enclosed.

This Committee urgently requests your County Society to take action at either a regular or special meeting before May 14 and advise the Councilor of your district of the action taken.

The State Committee will meet May 14 and if this action is approved of by component societies, will formulate at that time policies and details of a state-wide plan.

James A. Fisher, M.D.,
Secretary of the Committee.

Meeting adjourned.

Henry O. Reik, M.D.,
Secretary, Welfare Committee.

School Health Department

MATTERS OF INTEREST TO SCHOOL PHYSICIANS

Allen G. Ireland, M.D.,

Director of Physical and Health Education,
State Department of Education, Trenton

The Program for the School Physicians Section of the State Medical Society Convention is shaping up well. It is planned to devote a session to "open discussion of pertinent topics" of interest to every school physician; a combination of "symposium" and "forum".

An inquiry has been received concerning the possibility of a Graduate Extension Course for School Physicians, and the Department is investigating the possibilities.

Another suggestion touched upon the certification of school physicians, similar to the plan used in New York State. Pennsylvania and other States also require a special registration of school doctors; another topic that will be presented at the convention.

In the ventilation of school rooms, the modern standard is cool, moving air. To be free from body odors is of course desirable, but not essential. Investigations reveal that carbon dioxide content has no significance. A room temperature in excess of 68° is physiologically harmful, particularly to mental activity.

Recent studies in Toronto and Rochester indicate that hypertrophied tonsils, without infection, seem to have no correlation with physical health, mental development or scholastic standing.

X-ray pictures of the lungs are being taken for practically the entire student body of the Mount Holly High School. All health workers in New Jersey will watch this forward-looking move with interest. Dr. M. W. Newcomb is the prime mover in this epoch-making event.

Toxoid seems to have supplanted toxin-antitoxin as the physician's preference for diphtheria immunization.

School physicians are urged to participate in local Child Health May Day programs.

Children returning to school after having had certain acute infectious diseases should be prohibited, by administrative order, if necessary, from participating in physical activity programs. This should be a standing rule, and the reasons therefor should be explained to parents.

Without doubt, we have been lax in interpreting our work to the public. Understanding makes for coöperation, expansion, and expedition, not to mention adequate compensation. School physicians are, therefore, urged to seek opportunities for presenting their work before such groups as Parent-Teacher Associations, luncheon and civic clubs.

Probably, about 3% of school children have some degree of impaired hearing.

Growth records, charts, and graphs have replaced the old height-weight-age index and tables. No longer should we rate the individual child according to standards for the average. The fallacy has been exposed.

State Health Department

STATE REGULATION OF SWIMMING POOLS AND PUBLIC BATHS

J. Lynn Mahaffey, M.D.,
Director State Department of Health,
Trenton, N. J.

Sponsored by the State Department of Health, a bill is pending before the Legislature for State supervision of swimming pools and public baths. Assemblyman Marcus W. Newcomb, of Burlington County, a physician, introduced the bill, as Chairman of the Assembly Committee on Public Health. It is known as "Assembly Bill No. 167".

Agitation for better health regulation of such establishments culminated in the sponsorship of the measure by the State Department of Health. Several months ago, Dr. Samuel A. Cosgrove, of Jersey City, had his colleagues on the State Board of Health approve a program for the Department's Engineering Bureau to survey pools and baths. Harry P. Croft, of Trenton, Chief Engineer, made the survey upon which the Board's action was based.

State and municipal health officers, in conference at the State House, February 10, and the New Jersey Health Officers' Association, on February 11, endorsed the plan for State regulation.

Officially, the State Board of Health has gone on record that public swimming pools, indoor and outdoor, are potentially important sources of dissemination of disease. The number of pools in New Jersey is rapidly increasing, many of them in small communities where they are not subject to adequate local health codes and inspections.

The bill would authorize the department to prepare and enforce rules and regulations for the sanitary control of pools. Its laboratories will analyze samples from the pools.

It provides that after passage of the act no swimming pool or bath shall be operated without a license obtained from the State Department of Health. After investigation the department is authorized, in its discretion, to grant or refuse a license. The plan is to have a license operative until September 30, of this year, and annually renewed from October 1 at a yearly fee of $10.

The Health Department would have supervision over the construction, from a sanitary standpoint, as well as the operation of pools and baths, making and enforcing rules as to the purification of the waters and prescribing sanitary standards which all establishments must meet.

Pools and baths conducted by municipal, school, religious or charitable organizations would not be required to pay the license fee, although subject to all other State regulations.

Representatives of the Health Department would have access for purpose of inspection and interferences would constitute a violation of the act. Plans are required to be filed with the Department and approved before construction work is begun. Within a year after the adoption of the Act all pertinent information relating to existing pools and baths must be filed with the Department.

For a violation the Department could suspend or revoke a license and sue for a penalty of $100. Each day's continuance of the violation after the day of expiration of the formal notice would constitute a separate offense.

The Attorney General, counsel for the Health Department, would have the right to apply for an injunction in the Court of Chancery to close an establishment for violation of the Act. The bill includes pools or baths, outdoor and indoor, which are partially or entirely of artificial construction. It excludes residential pools for family and household guests. Local Boards of Health would have the right to prescribe rules not in conflict with those of the State Department of Health.

Chester G. Wigley, Consulting Engineer, of Atlantic City, discussed the pending bill before the Conference of Health Officials, February 10. In recent years a large number of public or semi-public bathing places have been established throughout the State, said Mr. Wigley. Some of these are carefully controlled and regulated for the purpose of preventing the spread of communicable diseases, while others are of the crudest nature and might be classed as "community bath tubs", consisting of a small dam built across a stream of doubtful quality. Many of them are connected with boarding houses or hotels in rural sections where they are subject to little or no control of a sanitary nature.

Without proper operation and supervision many of these bathing pools are a menace to the health of the persons using them. The bacterial contamination of many must at times be great, where no precautionary measures are used.

In the past there have been numerous occasions where cases of typhoid fever, enteric disorders, and infectious diseases of the skin, eye, ear and throat have been reported as being caused by bathing in water of an unsanitary character.

In most of these cases highly complex factors of environment and bodily resistance, as well as the difficulty of recovering from the water the specific causative bacteria, have left these cases inconclusive. It is only when the extensive nature and volume of these reports are taken into consideration with those where the proof is convincing that this part of public health work appears of importance. There is little doubt but that the financial losses to residents of the State from such infections are large when consideration is given to cost of treatment, often over a considerable period, and also of time lost from employment or useful occupation.

Communications

CONCERNING PAYMENT FOR MEDICAL SERVICE RENDERED TO THE PERSONNEL OF THE NATIONAL GUARD WHO BECOME INJURED OR ILL IN LINE OF DUTY

(The following letter from the office of the Adjutant General, in Trenton, addressed to Dr. James J. McGuire, was transmitted to Dr. Morrison, and by him passed along to the Editor for publication in the Journal. Noting that the Adjutant General had announced the intention of considering the "Schedule of Fees for Hospitalization and Medical treatment for the National Guard Personnel" [Bulletin No. 21, published by the War Department] as being *official* and *binding* upon our members if printed in the State Medical Society's Journal, we felt that the matter should first be presented to the Welfare Committee for consideration and acceptance or rejection. That course was followed and, on Sunday, April 23, 1933, the Welfare Committee approved and endorsed the project and authorized its publication in this Journal.—Ed.)

Dear Dr. McGuire: This office has had considerable difficulty the past few years in the payment of bills for hospitalization and medical treatment rendered the personnel of the National Guard injured or taken sick in line of duty. On account of certain areas of New Jersey being in the metropolitan district, the fees of surgeons and physicians are in excess of those authorized by the War Department.

In an effort to ascertain what is being done in adjoining States, I wrote the Adjutant General of New York, and quote from his reply:

"We published the schedule of fees in our Bulletin No. 4. May 24, 1929, so that every officer in the Guard received one, which primarily put it up to the unit commander. We also sent a copy to the President of the New York State Medical Society, who had it published in the Medical Society Journal; which made it more or less official with that organization. Then, if certain bills come in with items in excess of fees stated in the schedule, we simply return the bill for correction and enclose a copy of our Bulletin No. 4 with the request that they revise their bill accordingly. In the event that they fail to do so and send their bill back, we simply deduct the excess and approve their voucher for the amount specified in the schedule. Since the publication of the schedule in 1929 we have had only one case where it was necessary to take that action and the Medical Society sustained us."

Is it possible that this office may interest the Medical Society of New Jersey in this matter, so that the fees for services rendered the personnel of the National Guard during the year will conform to those authorized by the War Department?

Copy of Bulletin No. 21, this office, 1932, containing the schedule of fees for hospitalization and medical treatment for National Guard personnel is enclosed.

Very truly yours,

William A. Higgins,
The Adjutant General.

Subject: Schedule of Fees for Hospitalization and Medical Treatment for the National Guard Personnel.

To: The Adjutant General of each State, Territory of Hawaii, Porto Rico and the District of Columbia Militia.

(1) The enclosed copy of Schedule of Fees for Medical Treatment has been compiled for use in the settling of accounts for the hospitalization and medical treatment of National Guard personnel.

(2) The fees stipulated are the maximum amounts which may be allowed for the various services enumerated.

(3) In exceptional cases amounts in excess of those prescribed may be allowed by the Chief, Militia Bureau. In such cases a full and complete statement setting forth the necessity for the payment of excess charges should be submitted.

(4) A supply of the schedule is being forwarded to you, and it is recommended that they be so issued that they may be furnished hospitals and physicians who may be engaged in caring for sick and injured of the National Guard.

C. C. Hammond,
Major General,
Chief, Militia Bureau.

SCHEDULE OF FEES FOR MEDICAL TREATMENT

Examinations

General physical examination	$5.00
Examination of ears, nose and throat (separately or together)	5.00
Combined examination eye, ear, nose and throat	10.00
Dermatological examination	5.00
Neurological examination (complete)	10.00
Neuropsychiatric examination (complete)	10.00
General surgical examination	5.00
Orthopedic examination	5.00
Gastro-enterological examination	5.00
Proctoscopy	5.00
Genito-urinary examination without cystoscopy	5.00
Genito-urinary examination including cystoscopy	10.00
Cystoscopy with ureteral catheterization	25.00
Physical examination of heart or lungs, or both	5.00
Complete examination of heart, including electrocardiography	25.00
Bronchoscopy	40.00

Laboratory Tests

Blood:

Complement fixation test for syphilis	5.00
Complement fixation test for tuberculosis	5.00
Total erythrocyte count	1.50
Total leukocyte count	1.50
Differential leukocyte count	1.50
Examination of blood smear for malaria	2.00
Blood culture	5.00
Complete chemical examination of blood	10.00

Urine:

Routine, chemical and microscopical	1.50
Cultural examination	3.00

Feces:

Parasites and ova	2.00

Sputum:

Tubercle bacillus	2.00

Pneumococcus typing:

Avery method	3.00

Stomach Contents:

Routine, chemical (including test meal and withdrawal of stomach contents)	5.00

Spinal Fluid:

Complement fixation test for syphilis	5.00
Cell count	2.50
Bacteriological examination	3.00

Bacteriological Examination:

Pus or exudate	2.00
T. Pallidum (dark field)	2.00
Throat smear	2.00
Throat culture	3.00

Simple Fractures

Finger, one	15.00
Fingers, each additional	5.00
Carpal bone, one	15.00
Carpal bones, each additional	5.00
Metacarpal bone, one	20.00
Metacarpal bones, each additional	5.00
Radius or ulna (including Colles' fracture)	45.00
Radius or ulna, when suture or plating is necessary	75.00
Radius and ulna	60.00
Humerus	50.00
Humerus, when suture or plating is necessary	75.00
Toe, one	15.00
Toes, each additional	5.00
Tarsal bone, one	20.00
Tarsal bones, each additional	5.00
Metatarsal bone, one	20.00
Metatarsal bones, each additional	5.00
Tibia	50.00
Tibia, when suture or plating is necessary	75.00
Fibula	40.00
Fibula, when suture or plating is necessary	75.00
Pott's fracture	50.00
Femur	100.00
Femur, when suture or plating is necessary	150.00
Clavicle	40.00
Scapula	40.00
Rib, one	15.00
Ribs, each additional	5.00
Patella	50.00
Patella, when suture or plating is necessary	100.00
Pelvis	100.00
Pelvis, when suture or plating is necessary	150.00
Sternum	40.00

Skull	85.00
Vertebra	125.00
Sacrum	100.00
Coccyx	20.00
Maxilla superior (wiring if necessary)	75.00
Maxilla inferior	100.00
Malar bone	25.00
Fracture of nose	20.00
Epiphysial, separation of bone traumatic	45.00

Compound Fractures

Finger, one	25.00
Fingers, each additional	10.00
Carpal bone, one	25.00
Carpal bones, each additional	10.00
Metacarpal bone, one	25.00
Metacarpal bones, each additional	10.00
Radius or ulna	75.00
Radius or ulna, when suture or plating is necessary	100.00
Radius and ulna (plating or suture if necessary	100.00
Humerus	75.00
Humerus, when suture or plating is necessary	100.00
Toe, one	25.00
Toes, each additional	10.00
Tarsal bone, one	25.00
Tarsal bones, each additional	10.00
Metatarsal bone, one	25.00
Metatarsal bones, each additional	10.00
Tibia	75.00
Tibia, when suture or plating is necessary	100.00
Fibula	50.00
Fibula, when suture or plating is necessary	75.00
Femur	150.00
Femur, when suture or plating is necessary	175.00
Clavicle	60.00
Scapula	50.00
Rib, one	25.00
Ribs, each additional	10.00
Patella	75.00
Patella, when suture or plating is necessary	100.00
Pelvis	150.00
Pelvis, when suture or plating is necessary	175.00
Sternum	60.00
Skull, vault	125.00
Vertebra	150.00
Sacrum	125.00
Coccyx	50.00
Maxilla inferior (wiring if necessary)	100.00
Malar bone	50.00
Fracture of nose	40.00

Dislocations

Finger, one	10.00
Fingers, each additional	5.00
Carpal bone, one	15.00
Carpal bones, each additional	5.00
Metacarpal bone, one	20.00
Metacarpal bones, each additional	5.00
Toe, one	10.00
Toes, each additional	5.00
Tarsal bone, one	20.00
Tarsal bones, each additional	5.00
Metatarsal bone, one	20.00
Metatarsal bones, each additional	5.00
Elbow	50.00
Shoulder	50.00
Hip	75.00
Knee	75.00
Thumb	15.00
Vertebra	150.00
Maxilla inferior	15.00

Amputations

Finger, one	25.00
Fingers, each additional	10.00
Toe, one	25.00
Toes, each additional	10.00
Upper arm	100.00
Forearm	75.00
Hand	75.00
Thigh	125.00
Leg	100.00
Foot	75.00

Abscess, Incision and Drainage

Superficial	5.00
Deep	20.00
Brain abscess	150.00
Empyema, incision and drainage including rib resection	100.00
Oral (not to include dental or peridental)	15.00
Pericecal	100.00

Operations

Adenectomy, cervical, inguinal, etc. (minor)	25.00
Adenectomy, cervical, inguinal, etc. (radical)	100.00
Decompression of skull	150.00
Laminectomy	150.00
Tenotomy	25.00
Tenorrhaphy, one	40.00
Tenorrhaphy, each additional	10.00
Appendectomy	100.00
Cholecystectomy	150.00
Cholecystotomy	150.00
Intestinal anastomosis	150.00
Suprapubic cystotomy	100.00
Herniotomy	100.00
Nephrorrhaphy	150.00
Nephrectomy or nephrotomy	150.00
General peritonitis, laparotomy and drainage for	150.00
Splenectomy	150.00
Stone in the ureter, removal of	150.00
Intestinal obstruction, laparotomy	100.00
Thoracoplasty, for each stage	150.00
External urethrotomy	50.00
Suture of nerve	150.00
Orchidectomy	50.00
Excision of shoulder joint	150.00
Excision of elbow joint	150.00
Excision of wrist joint	125.00
Excision of hip joint	200.00
Excision of knee joint	175.00
Excision of ankle joint	125.00
Hemorrhoids	60.00
Resection rib	50.00
Bone graft (long bones)	150.00
Removal of sequestrum	75.00
Litholapaxy	75.00

Surgical Care of Traumatic Wounds

Incised	15.00
Lacerated	20.00
Punctured	15.00
Gunshot (depending on organ or tissue involved)	35.00 to 150.00

Eye Operations

Hordeolum	5.00
Chalazion	10.00
Iridectomy	75.00
Foreign body in interior of eye, removal of	100.00
Foreign body, removal from cornea (dissection)	25.00
Foreign body, removal from cornea (magnet)	20.00
Foreign body, removal from conjunctiva (dissection)	15.00
Foreign body, removal from conjunctiva (magnet)	10.00
Enucleation	100.00

Ear Operations

Paracentesis	25.00
Ossiculectomy	75.00
Acute mastoid	125.00
Radical mastoid	150.00
Lateral sinus, drainage	150.00

Nose and Throat Operations

Abscess, tonsillar	25.00
Abscess, pharyngeal	25.00
Tonsillectomy	40.00
Intubation	30.00
Extubation	30.00
Tracheotomy	50.00
Intranasal drainage of antrum	50.00
Intranasal drainage of frontal sinus	75.00
Drainage of internal sphenoid sinus	75.00
Radical ethmoid operation	75.00
Radical frontal operation	125.00
Radical antrum operation	125.00
Cauterization of larynx	10.00
Laryngectomy	150.00

Note: These amounts from simple fractures to and including the above include 15 days' routine after-care, exclusive of hospital charges, anesthetic and x-ray fees.

X-Ray

Hand, anteroposterior and lateral views	5.00
Wrist, anteroposterior and lateral views	5.00
Forearm, radius and ulna, anteroposterior and lateral views	5.00
Elbow, anteroposterior and lateral views	5.00
Arm, humerus, anteroposterior and lateral views	5.00
Shoulder joint, plain anteroposterior views	5.00
Shoulder joint, stereoscopic anteroposterior views	10.00
Clavicle, postero-anterior view	5.00
Scapula	5.00
Ribs, plain view over suspected area, 10 x 12 film	10.00
Location of foreign body in eye, the fragment charted in 3 planes and its dimensions ascertained by the method of Sweet or equivalent, complete	25.00
Foot, anteroposterior and lateral views	5.00
Ankle joint, anteroposterior and lateral views	5.00
Leg, tibia and fibula, anteroposterior and lateral views	5.00
Knee joint, anteroposterior and lateral views	5.00
Thigh, femur, anteroposterior and lateral views	7.50
Pelvis, 11 x 14, single film, anteroposterior views	10.00
Hip joint, plain anteroposterior view	10.00
Hip joint, stereoscopic, anteroposterior and lateral view	15.00
Spine, cervical, anteroposterior and lateral view	15.00
Spine, dorsal, anteroposterior and lateral views	15.00
Spine, lumbosacral, with coccyx, anteroposterior and lateral views	15.00
Skull, anteroposterior and lateral views	20.00
Sinuses, frontal and ethmoid, anteroposterior and lateral view	15.00
Sinuses, maxillary, anteroposterior and lateral views	15.00
Sinuses, mastoid, right and left sides for comparison	15.00
Jaw, upper or lower	10.00
Chest, for pulmonary or cardiac diagnosis, plain	10.00
Chest, for pulmonary or cardiac diagnosis, stereoscopic	15.00
Kidneys, right and left for comparison, 11 x 14 films	10.00
Ureters, right and left for comparison	15.00
Bladder, with injection, anteroposterior view	10.00
Fluoroscopy, when required, without film	2.00
Interpretation of Roentgenograms:	
Kidney films	5.00
Genito-urinary tract	5.00
Chest for pulmonary diagnosis, plain	5.00
Chest for pulmonary diagnosis, stereoscopic	5.00
Plain anteroposterior and lateral views of bones and joints	5.00

Miscellaneous

Skin grafting	10.00–50.00
Venesection	20.00
Application of plaster cast, chest	5.00
Application of plaster cast, torso	15.00
Application of plaster cast, torso and hips	20.00
Application of plaster cast, torso, entire body (chest to feet)	50.00
Application of plaster cast, thigh and hips	25.00
Application of plaster cast to spine	5.00
Application of spica bandage to hip	5.00
General anesthetic:	
(a) By visiting physician	10.00
(b) By intern or nurse	5.00
Note: In case of gas anesthesia an additional charge of $5 will be allowed.	
Intravenous injection, exclusive of cost of drug	5.00
Paracentesis abdominis	20.00
Paracentesis thoracis	20.00
Surgical assistant's fee, except for unusual condition	10.00
Allowance, per diem, for bed in ward	3.00
Allowance, per diem, for bed in semi-private room (when condition of patient makes necessary)	4.00
Allowance, per diem, for bed in private room (when condition of patient makes necessary)	5.00
Special nurse's services, per day:	
(a) With room and board	8.50
(b) Without room and board	7.00

X-ray therapy, superficial	5.00
Deep x-ray therapy, per treatment	10.00–25.00
(Maximum expenditure allowed not to exceed $100.)	
Radium therapy, per milligram hour	.05
(Maximum expenditure allowed not to exceed $100.)	
Lumbar puncture, including local anesthetic and obtaining fluid	15.00
Blood transfusion	50.00
Amount allowed for blood furnished, when not donated, per 100 cc.	10.00
Ambulance service—trip within city limits—day or night rate per trip	5.00
Ambulance service—trip requiring travel beyond city limits—rate per mile beyond city limits—rate per mile beyond city limits, one way only; this in addition to rate per trip within city limits	.50
Use of operating room	15.00

Visits

Office visits	2.00
Visit to home	3.00
Visits to hospital	2.00
Night visit away from office	5.00
Visits out of city or town*	3.00
Consultation.† Only by authority from Chief Militia Bureau	50.00

*$3 per hour for actual time consumed in travel out of city or town, plus actual expenses of transportation.

†In addition $3 per hour for actual time consumed in travel when consultant is required to make visit beyond city limits. This in addition to actual expense of travel.

AMERICAN MEDICAL GOLFING ASSOCIATION

The American Medical Golfing Association, headed this year by Dr. John Welsh Croskey, of Philadelphia, will hold its Nineteenth Annual Tournament over the Blue Mound Country Club course, Milwaukee, on Monday, June 12. One hundred golfers are expected by the hardworking local committee, composed of Dr. John W. Powers, Chairman; Drs. J. O. Dieterle, G. H. Fellman, J. C. Griffith, W. F. Grotjan, E. W. Miller, S. R. Mitchell, C. W. Morter, H. S. Roby and Ralph P. Sproule.

Play will begin at 8 a. m., with all teeing off on the beautiful and interesting Blue Mound course before 3.30 p. m. Dinner will be served at the Club at 6.30 p. m., followed by distribution of approximately 50 trophies and prizes for the 8 major events covering both 36-hole and 18-hole play. Past-President Frank A. Kelly, of Detroit, will be on hand with his inimitable stories. In addition, the local Committee promises that, at this tournament, Milwaukee's "fame" will not be lessened in quality or quantity.

Bargain prices will prevail this year; 36 holes of golf, dinner, prizes and entertainment, will be considerably less than $5 to Active Fellows. All Fellows are invited to play over the course for a practice round (on Sunday) before Monday's tournament. Fellows may play at all other courses in Milwaukee during the week.

Any male Fellow of the American Medical Association in good standing is eligible for membership in the American Medical Golfing Association, on acceptance of its By-Laws and payment of the enrollment fee. All communications concerning the golf tournament or enrollment can be addressed to Wm. J. Burns, Executive Secretary, 4421 Woodward Avenue, Detroit.

VIOLATIONS OF THE MEDICAL PRACTICE LAW

A Report from Dr. James J. McGuire, Secretary of the State Board of Medical Examiners

December 12, 1932, George R. Steneck, of Elberon, was found guilty of practicing medicine without a license, by the Judge of the Monmouth Court of Common Pleas.

January 18, 1933, Jules F. Uzdilla, a representative of the Tanney Laboratory, of Newark, was found guilty of practicing medicine without a license, by the Judge of the Asbury Park District Court.

January 18, 1933, Chester Vliet, a licensed chiropractor, of Asbury Park, paid the penalty for practicing medicine without a license. He exceeded his chiropractic license by giving electric treatments.

January 23, 1933, Lionel E. Dudley, of Jersey City, pleaded guilty to a charge of practicing medicine without a license, before Judge Ziegner of the First District Court of Jersey City, and paid his penalty.

January 24, 1933, the charge against Sol Fishman, of Jersey City, of practicing chiropody without a license was dismissed by Judge Ziegner of the First District Court of Jersey City.

January 26, 1933, August Miller, a licensed chiropractor, of Millville; Scott H. Rosser, a licensed osteopath, of Bridgeton; and Ellsworth Pierce, a naturopath, of Bridgeton, were found guilty of practicing medicine without license, by the Judge of the Cumberland County Court of Common Pleas.

February 2, 1933, Jacob H. Schmitter, of Paterson, was found guilty of practicing medicine without a license, by the Judge of the First District Court of Paterson. Schmitter required his patients to become members of a Homeopathic Society which was incorporated in the State in 1897, the Charter of which he had in his possession. He then proceeded to treat members by giving drugs.

February 21, 1933, Betty Parker, of East Orange, paid the penalty for practicing medicine without a license. The defendant was giving electric treatments and prescribing drugs.

February 24, 1933, Hester Armstrong, of Roselle Park, pleaded guilty to a charge of practicing medicine without a license, before the Judge of the Linden District Court. This defendant was prescribing drugs, some of which she manufactured.

February 24, 1933, Stanley Gawronski, of Elizabeth, pleaded guilty to a charge of practicing medicine without a license, before the Judge of the Linden District Court. This defendant also prescribed drugs.

SUMMER SCHOOL FOR HEALTH OFFICIALS

"Summer Courses" for public health officials will begin on June 27, at New Brunswick, forming part of the Rutgers' Summer Session and being taught by members of the Rutgers Faculty and of the Staff of the State Department of Health. This will be the eighth year that such Courses have been offered and, in that period, 105 men and women have enrolled and 70 have received the Rutgers *"Certificate in Public Health"*; while 37 Boards of Health are now employing such graduates.

Classes are held on each Tuesday and Thursday for 6 weeks, from 9.30 a. m. to 4.15 p. m., the complete Course covering 2 Summers; the first being devoted chiefly to studying the *principles* on which modern public health practices are based, and the second to the *application of those principles*. The cost is $25 for each Summer, payable to the University.

These Courses are intended for health officers, sanitary inspectors, and other employees or members of boards of health, and for persons expecting to enter this line of work. Those who are thinking of enrolling this year should communicate with the State Department of Health at an early date.

TO POLICY-HOLDERS

In these days of financial stress, many institutions, including banks and a few insurance companies, have been forced out of business. This is the case with the company which has been carrying your "Accident and Health Policy", the Independence Indemnity Company; which was placed *in receivership* on April 19 and this naturally presented a serious problem to this Committee.

For any advance premium you have paid, your only legal claim against the Receiver would have been for the unearned premium, with considerable doubt as to any recovery. However, your Committee immediately took steps to save the situation and to protect your interests, and we are happy to tell you now that arrangements have been concluded with the National Casualty Company, of Detroit, to take over the risk of all members of our Society and in conjunction with E. & W. Blanksteen, 76 Montgomery Street, Jersey City, who have acted as our agents, to assume the entire loss of the unearned premium, which otherwise you individually would have had to bear.

The new Company has agreed to *duplicate in its entirety the policy contract you previously held,* and at the same rates and with the same service you have always enjoyed through the Blanksteen office.

The Committee has carefully investigated. not only the financial stability but the history, record and methods of claim payments of this Company and unhesitatingly recommends it to you, with the approval of the Officers and Trustees of the Society.

Yours very truly,

Committee on Health & Accident Insurance,
Frank W. Pinneo, Chairman.

Woman's Auxiliary

Atlantic County

Reported by Mrs. James North

The Woman's Auxiliary to the Atlantic County Medical Society held a regular meeting Friday evening, May 12, at the Chalfonte Hotel, Atlantic City.

Mrs. Daniel Reyner gave a report of the Annual Luncheon and Bridge held at the Hotel Claridge May 10.

Mrs. E. H. Harvey, Chairman of the Courtesy Committee. reported that flowers had been sent to Mrs. Samuel F. Gorson, who is convalescing from a recent illness.

The Chairman of the Nominating Committee. Mrs. Samuel L. Salasin, reported the following ticket: President, Mrs. Joseph Poland; First Vice-President, Mrs. James North; Second Vice-President, Mrs. Bernard Crane; Treasurer, Mrs. Robert A. Bradley; Recording Secretary, Mrs. Lawrence A. Wilson; Corresponding Secretary, Mrs. Manuel J. Mallay. There were no nominations from the floor. It was moved and seconded that the Secretary cast the ballot.

Mrs. James H. Mason welcomed the new President and then invited the Auxiliary, for a day in June, to Dox Folly, the Summer camp of Drs. Uzzell, Davidson and Mason.

After the business meeting, cards were enjoyed.

Camden County

Reported by Mrs. G. R. West

The Annual Meeting and Luncheon of the Woman's Auxiliary to the Camden County Medical Society was held at Iron Rock Park Country Club on May 2, with approximately 65 members and guests present.

Mrs. Lippincott, the President, presided over a short business meeting at which the Nominating Committee gave its report and the following officers were unanimously elected for the ensuing year: President, Mrs. A. Haines Lippincott; President-Elect, Mrs. E. C. Pechin; First Vice-President, Mrs. Joseph E. Roberts; Second Vice-President, Mrs. Albert B. Davis; Third Vice-President, Mrs. Robert S. Gamon; Recording Secretary, Mrs. O. R. Carlander; Corresponding Secretary, Mrs. Reba Bushey; Treasurer, Mrs. E. McConaghy; Directors—Mrs. O. W. Saunders and Mrs. H. Westcott.

After the business meeting, Mrs. E. C. Taneyhill, Field Secretary of the State Medical Society, gave us a very delightful talk, entitled "Quacks and Nostrums".

We all enjoyed her talk very much, and I would suggest that all who have not heard her, endeavor to secure an engagement at an early date.

Hudson County

Reported by Mrs. James M. Murphy

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held on Monday, May 8, at the Y. W. C. A., with the President, Mrs. George M. Culver, presiding. The minutes of the previous meeting were read and approved.

The Treasurer reported a balance of $950.16 in the Savings Account and $184.50 in the Checking Account.

The President read a letter of resignation from Mrs. Frank Nicholson, Chairman of the Nominating Committee, and announced that Mrs. Arthur Largay had been appointed to fill the vacancy.

Mrs. Largay then gave her report of the nominations: President, Mrs. Frank P. Nicholson; First Vice-President, Mrs. A. E. Jaffin; Second Vice-President, Mrs. Charles B. Kelley; Recording Secretary, Mrs. John N. Connell; Corresponding Secretary, Mrs. Frank Haggerty; Treasurer, Mrs. Harry J. Perlberg.

It was moved by Mrs. Ruvane, seconded by Mrs. Herbert Culver, that the report of the Nominating Committee be accepted and the nominations closed. Motion carried. The Secretary then cast the ballot.

Mrs. Culver spoke in appreciation of the splendid coöperation of the Auxiliary during her presidency, and Mrs. Nicholson thanked the members for the honor placed in her trust, and hoped to follow in the footsteps of her 3 predecessors.

The members voted to have the usual Spring Luncheon at the Arcola Country Club, on Tuesday, June 13, with Mrs. Charles Kelley as Chairman and Mrs. Harry Perlberg to receive reservations and checks.

The following Delegates and Alternates were appointed, for the Annual Convention in June to be held in Atlantic City: Delegates, Mrs. George M. Culver, Mrs. William Freile, Mrs. John Nevin, Mrs. Warren J. Duckett, Mrs. Frank P. Nicholson, Mrs. Norman L. Rowe. Alternates, Mrs. Henry Klaus, Mrs. Edward G. Waters, Mrs. Joseph J. Ruvane, Mrs. Charles B. Kelley, Mrs. Stanley R. Woodruff, Mrs. Louis Pyle.

The Reciprocity Meeting (to which representatives from all Auxiliaries having health programs had been invited) followed.

The speaker was Dr. Arthur P. Hasking, Assistant County Physician, who took for his subject "The General Welfare Work of the State, County, and Municipalities". The ramifications of welfare work was graphically pictured. When welfare work is considered to include the care of the mentally sick, the feebleminded, epileptics, and the tubercular; also inmates of the alms-house, penitentiary, jail, children under the Board of Guardians, and widows receiving pensions, it assumes gigantic proportions.

Dr. Hasking praised the work being done, but feared all institutions may be curtailed in their work if further reductions in budgets have to be made.

The following State Officers were present: Mrs. Charles Franklin Adams, of Trenton; Mrs. F. J. McCauley, of Glen Ridge; Mrs. Dan Renner, of Skillman; Mrs. Frederick Kinch, of Westfield; and Mrs. Edwin Clarke, of West Englewood.

Mrs. Adams addressed the meeting and told of a Bill, up before the State Assembly, to allow Osteopaths the use of our hospitals, and asked that we send a telegram of protest to Dr. Newcomb.

It was moved, seconded and carried that this be sent in the name of the Woman's Auxiliary to the Hudson County Medical Society, having been approved by the President of the Hudson County Medical Society, Dr. Louis Pyle, who is also a member of our Advisory Board.

The members and guests were then invited to adjourn for a social hour when tea was served. The tea table was gay with Spring flowers. The newly elected President, Mrs. Nicholson, and our organizing President, Mrs. William Freile, poured, and a group of the young matrons served.

Passaic County

Reported by Mrs. B. W. Botbyl

Mrs William A. Dwyer was unanimously elected President of the Woman's Auxiliary to the Passaic County Medical Society at the Annual Luncheon Meeting held May 11, at the North Jersey Country Club.

Other Officers elected were: First Vice-President, Mrs. Burt W. Botbyl; Second Vice-President, Mrs. O. R. Hagen; Secretary, Mrs. Edward Leonard; and Treasurer, Mrs. Sydney Brooks.

Mrs. Charles B. Russell, retiring President, presided at the meeting and introduced the guest speakers, Mrs. Charles Franklin Adams, of Trenton, President of the State Auxiliary, and Mrs. Dan Renner, Corresponding Secretary of the State Auxiliary, and Mrs. Olav Berg, of this city.

Annual reports were presented by Mrs. James P. Morrill, Chairman of the Program Committee; Mrs. James E. Phelps, Chairman of the Entertainment Committee; Mrs. William Dwyer, Social Committee; Mrs. Burt Botbyl, Publicity Committee; Mrs. A. M. Schultz, Public Relations; Mrs. James Barr, Hygeia; and Mrs. Edward Leonard, Membership. Mrs. George Tuers was Chairman of the Nominating Committee.

The members present were: Mrs. G. E. Tuers, Mrs. C. B. Russell, Mrs. A. M. Schultz, Mrs. J. E. Phelps, Mrs. E. F. Leonard, Mrs. W. A. Dwyer, Mrs. A. F. Meneve, Mrs. A. B. Meneve, Mrs. F. Meyers, Mrs. T. F. O'Grady, Mrs. W. Neer, Mrs. R. Neer, Mrs. G. Walton, Mrs. P. Denton, Mrs. R. J. McDonald, Mrs. B. E. Wilkinson, Mrs. H. Briody, Mrs. J. Ritter and daughter, Mrs. H. H. Nye, Mrs. J. De Rosa. Mrs. J. Barr, Mrs. M. M. Chapnick, Mrs. M. F. Birely, Mrs. A. C. Linares, Mrs. C. H. Scribner, Mrs. R. Vreeland, Mrs. Burt W. Botbyl, Mrs. J. P. Morrill, Mrs. J. R. Lomauro, of Passaic; Mrs. G. B. Flood, Mrs. A. E. Browne, Mrs. B. Pal, Mrs. L. Becker, Mrs. L. Bohl, Mrs. A. Shulman, Mrs. William Spickers, Mrs. M. S. Joelson, Miss Noel Russell, Miss Louise Morrill and Mrs. F. Lee.

Somerset County

Reported by Mrs. A. Levy

A regular meeting of the Woman's Auxiliary to the Somerset County Medical Society was held at the Nurses' Home of the Somerset Hospital.

The following Officers were elected for the ensuing year: President, Mrs. Lancelot A. Ely; First Vice-President, Mrs. A. L. Stillwell; Treasurer, Mrs. Edgar Flint; Recording Secretary, Mrs. A. Levy; Corresponding Secretary, Mrs. G. E. Barbour; Directors, Mrs. Dan Renner, Mrs. Edgar Flint, and Mrs. Lancelot Ely, ex-officio. Delegates and Alternates were appointed for the Annual Convention to be held in June.

After a brief business meeting, the members adjourned to join the doctors, who were listening to an address by Dr. Ill.

County Society Reports

BURLINGTON COUNTY

Joseph M. Kuder, M.D., Reporter

The regular session of the Burlington County Medical Society was held on May 10 at the Burlington County Hospital, Mt. Holly, with President John S. Conroy presiding. There being no unfinished business, the question concerning the proposals of the State Emergency Relief Administration, as outlined at a recent meeting of the State Society's Welfare Committee, was subjected to a full discussion; and, in principle, the plan was favorably received. Full approval was deferred until further details are available. A special committee, comprising Drs. Joseph M. Kuder, Nathan Thorne, and Richard Anderson, was appointed to receive and report back to the County Society any further developments. The Society wishes to emphasize the point that its acceptance of any plan of this nature is only because of, and for the duration of, the present peculiar emergency.

The application of Dr. Charles S. Shapiro, of Maple Shade, was automatically referred to the Board of Censors for consideration.

The County Medical Society wishes to commend the Burlington County Tuberculosis League for its intensive study of the question of tuberculosis incidence in public school children, and it is hoped

that, as a result of this study, valuable data may become available for publication. This work is being carried on under the capable supervision of Dr. Marcus Newcomb, Medical Director of the County Tuberculosis Sanatorium.

At the conclusion of the business session, Dr. Howard Curtis, Chairman of the Section on Obstetrics, announced as the orator of the day, Dr. Clifford B. Lull, of Philadelphia, who presented a very illuminating and comprehensive exposition of the "Toxemias of Pregnancy". Following a full discussion of Dr. Lull's presentation, the meeting was adjourned to re-convene in special session next month, at the call of the President.

CAMDEN COUNTY

Report of a Special Committee, in the Camden County Medical Society, to Study the "Costs of Medical Care"

Your Committee, in undertaking this study of Medical Economics, decided that an abstract discussion of the so-called *Majority Report* would be futile. Instead, as a preliminary to the study, we undertook a brief survey of those Institutions and Agencies in our own County which have to do with the care and treatment of the people *en masse*, feeling that with a proper understanding of the operation of those organizations we would be better able to estimate the value of the *Recommendations* made in the *Majority Report*. Our report will be divided, therefore, into 3 sections: (1) An outline of the findings in our survey of Camden County Institutions; (2) a discussion of the *Majority Report;* and (3) conclusions and recommendations submitted for your approval.

Section I

Findings of Survey of Camden County

(1) *Medical Aspect of School Work.* After careful investigation of the activities of school physicians and school nurses, despite adverse criticisms which have been heard on this floor, the Committee came to the conclusion that, fundamentally, the ethics and procedures of the medical and nursing forces in the schools were perfectly sound. While there may be individual cases open to criticism, they were, generally, due to insufficient help for proper social service work. It is the *principle* of the school physician that no actual treatment, of any sort, shall be given to the pupil, and that where treatment is required, the individual should be referred to his own family physician. Wholesale administration of diphtheria toxoid is not desired by the school physician, but failure on the part of the private physician to urge and support this very important work has made it necessary in some places for the school physician to undertake it as a duty.

It is our opinion that the school physician receives insufficient remuneration for the large amount of work demanded of him, and which renders it impossible to do the job as thoroughly as he would wish. Conflicts and irregularities have arisen from lack of proper control. The Committee feels that the public school work should be under control of the City Health Department or there should be, on the Board of Education, a physician recommended or approved by the County Medical Society, to act in an advisory capacity. It seems impossible that the laity should have the necessary knowledge for efficient control of school health matters.

Nursing Social Service Work is, we find, inadequate because the force is not sufficient to cover the ground. This explains why some children come to our free Clinics who should have consulted their own physicians. It is a principle of the school nurse, as well as of the school physician, to attempt no form of direct treatment, make no suggestions as to procedure, and to refer all students requiring medical care to the family physician. It is the expressed desire of the authorities that any irregularities in this matter should be reported. Irregularities, when traced, have been found generally to result from conditions in smaller outlying communities and not to the city of Camden.

There is apparent need for Mental Hygiene Clinics to treat behavior cases, not for the mentally deficient child, but for the child difficult to discipline; a Clinic like that established at Cooper Hospital, under supervision of the State, and with the idea that when and if it proves itself valuable, it shall be turned over to the proper local authorities.

There is also great need for some sort of Dental Clinic to take care of the school child.

(2) *Coroners.* The coroner should be, preferably, a physician, but if it continues to be the policy to have coroners appointed or elected from among the laity, there should be appointed a coroner's physician adequately trained in making autopsies, in toxicology, in gunshot wounds, and other subjects which pertain particularly to that position.

(3) *Health Department.* Epidemiology and inspection of milk and food supply should, quite rightly, be an undisputed part of the duties of the Health Department. Sanitation of industrial plants is under State control, and in Camden we find that splendid work is being accomplished in that field in spite of the fact that only 1 worker is allotted to this district.

In consideration of health camps, it has been pointed out that such institutions have been diverted from their original object, which was antituberculous. The idea was not to feed the poor, but to care for the under-nourished children of all classes who must always be considered potential T. B's. This is definitely a preventive medicine movement, which need not clash with the private physician.

The pre-school or Baby Clinics are not run in competition with the doctor. In all cases, abnormalities and deviations from the normal are referred to the family physician. The thought is that by regularly weighing infants, the scale will indicate the need for readjustments in diet or nursing formulas long before there are obvious manifestations of malnutrition, and thereby much valuable time will have been saved. The criticism that nurses of these Clinics "have been changing or prescribing milk formulas" was denied by Dr. Stone for the City Clinics. Part of the work in these Clinics is training mothers in the elements of hygiene, for which the general physician has little or no time.

With reference to vaccination and diphtheria immunization, the Health Department has no desire to do this work on a large scale, but feels that it is a job which must be done in the public interest and until such time as the medical profession, as a whole, actively supports this movement, holds itself obligated to vaccinate and immunize all who apply.

The value of the City Laboratory is appreciated by all. It is believed that a more central location for this institution would greatly increase its usefulness, and it should be more extensively used

for those upon whom the fees of private laboratories are a burden, but they should not be considered as running in opposition to any such private laboratories.

We find that the city is well supplied at present with Public Health Nurses, there being 27 actively on full-time duty: Bureau of Charities, 3; Insurance Companies, 5; School Nurses, 10; Health Department, 9; total, 27. However, owing to the fact that these nurses are under several different controls, there is some over-lapping. If they were united under one executive head, all departments of work in the city would be well provided for.

Emergency Relief and Care of the Indigent. In this set-up, arising from present economic conditions and provided for by the State authorities, extensive and exhaustive social service investigation has been made. Dr. Stone implies that, as the present emergency subsides, this data and set-up will be relinquished by the State to the local authorities, and can then be carried on for care of the normal number of indigents. It is recommended that for the future, in place of the "Poor Doctor", the community will pay private practice physicians, who are willing to do such work at a reduced rate. Many such patients are being and have always been treated without hope of any compensation whatsoever.

Funds and Interference. Our Director of Public Health is positive that an appropriation of $1 per capita would be sufficient to provide adequate public health service for this community. The Health Department in Camden, except for some minor unimportant appointments, is not hampered by political interference. Future development and modification of health work, as suggested by Dr. Stone, met with approval of the Committee. This consists in the creation of a Director of Public Welfare, under whom shall be 2 departments: (1) the Division of Public Health; (2) the Division of Aid and Relief. Such a plan would coördinate many activities which at present overlap and are cumbersome because of a division of authority.

Private Hospitals. In a survey of the 2 private hospitals located in Camden County, your Committee was satisfied with the economy practiced in both and also with their general management. Such weakness as we noted pertained to the hospital situation now existing all over throughout the country. It was felt that better coöperation should exist between the hospital and the profession at large; that greater care might be exercised in returning patients treated in the wards or dispensaries to the family physician at the conclusion of the course of treatment; and that only such patients as are indigent, or had not been referred to the hospital by a practicing physician, or require continuation of treatment by a specialist, should be referred to the dispensary upon discharge from the hospital.

Improvement in hospitals' social service departments is much needed, and, when perfected, would not be an added cost but a distinct saving in hospital management. Such social service work should include supervision of the type of patient admitted for free treatment; and in addition, the hospital should particularly concern itself with the passing on of data concerning each patient to the family physician upon discharge from the hospital. As an aim for the future, it is firmly believed that those physicians who treat charity patients, either in ward or dispensary, should receive some remuneration. The charity patient is a "ward of the city", and there seems no reason why the hospitals, or groups of physicians associated with those hospitals, should continue to care for these charity patients without compensation. This is a burden which rightfully belongs to the tax-payer. The advisability of establishing part-pay Diagnostic Clinics for those patients who, while not indigent, find thmeselves unable to pay the fees involved in such diagnostic work in a private way, is a matter for serious consideration.

Free Hospitals and County Institutions. Here, data as to the economic administration was not available. It was the consensus of opinion that further enlargement of the Hospital Center at Lakeland is inadvisable, for the reason that great increase in the number of patients handled would necessitate a larger and more active consulting staff, and that the remote location would place a considerable burden upon members of the visiting staff. It is recommended that there should be, on the Hospital Committee of the Board of Freeholders, a physician representing the County Medical Society, to act in the capacity of a liaison officer.

Compensation Cases. The tendency for industrial plants to employ resident or full-time physicians to care for their employees, and for insurance companies to establish clinics and hospitals for treatment of the employees of their assured clients, is viewed with alarm as *a form of contract medicine.* However, in South Jersey it is believed that the status of compensation work carries with it very few ills at present. It was the consensus of opinion that when compensation patients are treated in the wards or clinics of private hospitals, the hospitals and physicians in attendance should receive adequate remuneration.

Government Hospitals. While there are no Army, Navy or Marine Hospitals in Camden County, it is a well-known fact that any "ex-service man" can be treated for any condition, whether as a result of his service in the military forces of the United States or not, free of charge, at the Naval Hospital in Philadelphia. Many ex-service men who are well able to pay for adequate care are taking advantage of this Institution, and this throws the Government Hospitals into direct competition with the profession; a practice which most certainly should be discontinued.

Section II

Discussion of Majority Report

In leading up to a discussion of the *Majority Report,* it would seem that the National Committee has not sufficiently stressed, in its estimate of the situation, the enormous amount of money expended on luxury medicine, quacks, patent medicines, and unduly expensive semi-official proprietary drugs, so that the *per capita* cost for legitimate, adequate, medical care has been somewhat over-estimated.

Now let us consider, in order, the various *Recommendations* in the *Majority Report:*

Recommendation No. 1, which advocates more extensive development of organized groups of physicians, dentists, nurses, etc., while at the same time recommending preservation of personal relationship between patient and physician, is, we feel, rather impractical. This plan would seem to advocate that nearly all physicians now engaged in the practice of medicine should be united in groups or centers from which they should carry on their practice. It is our opinion that this would take away the local physician, and certainly not add to the convenience of the patient; that it would be impossible to maintain that personal relationship, which is such an important factor in the present American system; and that such

grouping is essential only for the diagnostic study of patients and consultations which constitute, after all, a relatively small percentage of those patients who consult the general physician day by day. The great need is not for cheaper routine medical care but for more reasonable rates for that small percentage of the great middle class which needs highly specialized care or more thorough investigation than can be offered in the office of any one practicing physician. Therefore, your Committee believes that, rather than reduce the whole of the practice of medicine to greater centralization, there should be created in those medical centers already in existence—namely, hospitals in the large communities—a part-pay or moderate-pay Clinic for the care of those of limited means who need such thorough investigation. Patients to such Clinics *should be accepted only upon the recommendation of a regular practitioner*, and when study or examinations have been completed, *the patient should be returned to the referring physician* with a report of findings. Remuneration for this work should not only cover the cost to the institution, but should, in addition, yield some monetary return to those physicians who did this work. For instance, the basic cost of a complete survey should be carefully estimated, and *the referring physician*, taking this into consideration, *should then be in a position to advise the fee for his individual patient.*

Recommendation No. 2, in which the Committee suggests the extension of basic public health service, is one which warrants little discussion, except to say that every effort should be made, in the extension of such service, to avoid taking away bread and butter from the general practitioner.

Recommendation No. 3, suggesting various methods of group-payment, based on insurance, taxation, or what not, does *not seem* to be, at present, a *practical* one. Such insurance or such taxation would be a terrific burden, and it is felt to be *unnecessary.* In normal times, the average family is well able to take care of its casual visits to the physician and most of the simple illnesses by which they are afflicted. The indigent will always be a burden to the community. Much abuse and much unnecessary work would result from the absolute guarantee of assured payment for all medical care. The encouragement of various industries to insure the worker against illness, in conjunction with the already existing protection against injury sustained in the plant, is an idea worthy of serious consideration. Such additional protection should not be a burden to any one employed. With the wage-earner in a family thus protected in normal times, many of the hardships attendant upon illness would be removed except in unusual cases. With the worker drawing his salary, the average family is able to meet the cost of medical care. The great hardship arises when the wage-earner is not only not deriving his income but is faced with the expense of prolonged illness.

Recommendation No. 4 suggests that agencies including lay members be formed for the study and coördination of medical service. This is a broad statement, and it would seem to indicate a desire on the part of the Majority to permit the laity to put its finger in the "medical pie". It is the feeling of your Committee that physicians are well able to take care of their own business; and that, already, political influence hampers and distorts the proper functioning of many institutions and agencies. Rather than agree with this Recommendation, we would insist that there should be a still further removal of politics or political interference from anything that has to do with medicine, except for financial control in the care of the indigent.

With regard to coördination of rural and suburban service, much can be done for improvement. At present, hospital facilities are open to patients from rural districts referred by their physicians, for the treatment of the poor. With the establishment of Part-Pay Diagnostic Clinics, and expansion of hospital social service departments, we feel that such coördination would be complete. The Public Health Departments in the more rural districts are, in many cases, in the hands of untrained members of the laity. For the future, it would seem advisable to appoint as Health Officers in these rural communities younger physicians who will have had the rudiments of public health work in the course of their medical training, and that they look upon the trained Public Health Officers of the larger communities as consultants or advisers.

Recommendation No. 5, which has to do with the training of physicians, nurses, pharmacists, midwives, and hospital executives, leaves little room for discussion. Your Committee is in accord with the suggestions involved in this Recommendation, and wishes particularly to stress the advisability of a course in the fundamentals of public health work for the undergraduate, for the purpose of rendering smoother, in the future, the coöperation between physician and Public Health Officer, and of furnishing material for filling of public health offices in the smaller communities. There might be some question as to the education and training of midwives. Certainly more deliberation should be given to the type of training and control, and to the status of midwifery, than it was possible for your Committee to undertake in the course of the present investigation.

Section III

Conclusions

The present system or status of the practice of medicine in the United States is largely an outgrowth of the demands and desires of the citizenry of a commonwealth which is the greatest experiment of all history in an attempt at government by and for the governed. Just as our political structure, though cumbersomely and painfully, eventually shapes itself according to the will of the people, so medical practices in vogue are largely a result of what the public demands and expects. Innovations can only be established after the public mind has been trained to accept them. It would be as impossible to legislate a system of medical practice as it has been to legislate against the use of alcohol. It would be equally difficult for the profession to impose any sudden radical changes in procedure upon the public. The great progress in medicine during the past 60 years; the unremitting effort on the part of the profession, not merely toward perfection of treatment, but, more important, toward prevention of disease; and, the enormous development of hospital centers and free clinics; are facts which amply demonstrate the persistent concern of the profession for the public welfare, often to its own economic detriment.

These opinions should not be interpreted as implying smug satisfaction with conditions as they exist. No profession recognizes and admits so unreservedly its own shortcomings as does the medi-

cal profession. However, we are led to the conclusion that the present system, admitting certain defects, is reasonably suitable to the existing economic and social structure of the American people, and that safety demands that development and adjustments of this system shall be left in the hands of the medical profession. As a result of these conclusions, and of its findings in a study of County Institutions, your Committee presents 2 groups of Recommendations for your consideration:

GROUP 1: RECOMMENDATIONS AT LARGE

(1) That the economic importance of the general physician shall be emphasized; and that the public shall be trained back to a proper use of the "family doctor" as the key-man of the structure.

(2) Except for further development of the part-pay Diagnostic Clinic, any effort toward wholesale centralization of the medical profession into groups shall be vigorously opposed.

(3) Wholesale, enforced, nation-wide sick insurance is not feasible. Assumption of the burden of medical cost by government appropriation would lead to many abuses and would throw the profession directly under political control; and *should be vigorously resisted.* However, coöperative health insurance of employees in industry has been in practice for some time, has demonstrated its usefulness, and should be strongly advocated.

(4) Public health work should be supported and extended along its legitimate avenues; and in this work, there should be closer affiliation between the Health Departments of smaller communities and those of the larger centers, which have a more highly trained personnel. Further, basic courses in elementary public health work should be established in medical schools, for the purpose of furnishing capable lieutenants in health work, and of insuring, for the future, a better understanding between the Health Officer and the medical practitioner.

(5) Further study should be made as to the status and training of midwives, and the formation of some definite policy to cover this phase of medicine, should be advocated.

(6) Our patent laws should be revised so as to prevent exploitation in the form of exorbitant prices for useful remedies.

(7) Army and Navy hospitals must be forced to discontinue the indiscriminate hospitalization of ex-service men, not invalided or injured while in actual service.

(8) As an objective for the future, the burden of free work should be borne to a greater extent by the community. Eventually, the physicians doing this work in hospitals should receive some compensation.

GROUP 2: LOCAL RECOMMENDATIONS

(1) Establishment in our *private* hospitals of experimental Part-Pay Diagnostic Clinics for patients of moderate means.

(2) Physicians treating compensation patients in the wards and clinics of our *private* hospitals be permitted to collect a uniform fee for their services.

(3) Social service departments in our hospitals should be expanded to control the type of patients admitted for free service; and, for the purpose of insuring coördination with private physicians on the outside.

(4) Centralization of relief and public medical work in the city of Camden under one head or bureau, for the purpose of better coördination, and as a measure of economy—this to include Public Health Department, School Medical and Nursing Departments, Public Health Nurses, and Medical Treatment of the Indigent. And until such time as centralization has been accomplished, and so long as the Boards of Education in the various communities continue to direct medical activities in the schools, that a seat on each Board of Education be granted a representative of the medical profession recommended by the County Medical Society.

(5) A representative of the County Medical Society should be granted a seat on the Hospital Committee of the Board of Freeholders, in an advisory capacity.

(6) Coroners should be physicians; but so long as this office is filled by members of the laity, there should be created a new office, that of *Coroner's Physician,* and that position should be filled by an adequately trained member of the medical profession, acceptable to the County Medical Society.

(7) All State or municipally operated Clinics, such as Baby Clinics, Health Camps and School Clinics, should be under the direct supervision of a physician of approved standing.

(8) That the medical profession of our County should present a more united front in support of those measures of preventive medicine of proved efficacy, such as diphtheria immunization and periodic health examinations, and more time should be devoted at the County Society meetings for consideration of matters of social-medical importance in the community; and, through a more firmly knit union of members of the profession within the County Medical Society, the opinion of the profession in the County shall be brought to command that influence upon medical issues which rightfully belongs to it.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

A special meeting of the Society was held May 2 at the Bridgeton Hospital for the consideration of the suggestion of the State Society's Welfare Committee, presented through the County Society's representative, Dr. M. F. Sewall, that the care of indigent patients be paid for by the State at the rate of $1 for office visits, $2 for home visits, and $25 for maternity cases.

The proposition was freely discussed. Some felt emergency time and appropriation were so indefinite that there was doubt of the advisability of venturing on what might result in a radical change for the profession. Others said the work has always been done gratuitously and the medical profession has contributed more than any other group of citizens of the community, and that, since the merchants are doing business under a like method, it seems entirely justifiable to adopt the plan with such safeguards as should protect the profession.

A motion was passed authorizing our Secretary to inform the Welfare Committee of the Society's willingness to coöperate.

The President was authorized to appoint a committee of 5 for coöperation with the District Councilor, Dr. Crowe, in supervising the administration of any such plan adopted by the State Welfare Committee.

ESSEX COUNTY

The Academy of Medicine of Northern New Jersey, Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

A meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, May 8, at 8.45 p. m., with 45 members and guests present.

A moving picture film was shown, illustrating the "Method of Conducting Tests of the Vestibular Apparatus" and, by means of animated drawings, the "Nerve Connections Involved in Vestibular Nystagmus".

Dr. Lewis Brown read a paper on "Vasomotor Rhinitis", which was followed by a general discussion.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The regular meeting of the Gloucester County Medical Society was held on May 18, at the Oakwood Country Club.

Dr. James E. Talley, Professor of Cardiology, University of Pennsylvania Graduate School of Medicine, spoke on the "Treatment of Heart Disease". Dr. George Griffith, of Philadelphia, exhibited Motion Pictures of the Heart. The whole subject matter was exceedingly interesting.

The Society endorsed the Emergency Relief Administration, respecting medical care.

A very extensive report was made by the Committee on Public Health.

A luncheon was served at the close of the session.

The following members were present: Drs. William W. Pedrick and Charles Pedrick, of Glassboro: Ralph Hollinshed, of Westville; Stewart and H. L. Sinexon, of Paulsboro; Victor I. Barrows, Pitman; Samuel Ashcraft, Mullica Hill; H. Wilson Stout, Wenonah; Duncan Campbell, Fuller Sherman, Dorothy Rogers, C. A. Bowersox, E. E. Downs and H. B. Diverty, of Woodbury; W. J. Burkett and I. W. Knight, Pitman; A. B. Black, Mickleton; B. A. Livengood, Swedesboro; Oran A. Wood, Paulsboro; H. M. Fooder, Williamstown, and C. I. Ulmer, Gibbstown.

Dr. Emma Richardson was Delegate from Camden County, and Drs. Charles Kaufman and Garrett Miller were Delegates from Cumberland County.

HUDSON COUNTY

Charles Sirken, M.D., Reporter

The regular meeting of the Hudson County Medical Society was held at the Carteret Club, Jersey City, on May 2.

Announcement was made of a Medical Center Nurses' Registry through which nurses may be obtained for 24 hours, 12, 10 and 8, or other hourly nursing services.

There was considerable discussion concerning compensation of physicians for the care of indigents, as proposed by the Emergency Relief Administration for New Jersey. It was explained that Colonel Bigley, State Manager of the E. R. A., has requested coöperation of the State Medical Society in a plan for compensating physicians for care of sick indigents. The subject was discussed by Drs. Quigley, Maras, D'Acierno and Woodruff. Some of the arguments were, as follows: A forerunner of state medicine—distinct departure from medical ideals—political control—might become a racket—so many restrictions needed it could not work well—consideration for our rural doctors in distress—etc.

Dr. Arlitz thought every member should be requested to consider this carefully and we should call a Special Meeting to give it proper consideration.

Dr. Alexander moved that this matter be postponed for a period of about 10 days and then have a Special Meeting to decide the question definitely. His motion was regularly seconded and carried.

Dr. Sprague moved that the Hudson County Medical Society instruct its Delegates to the State Society to vote against any specialist practice determination in New Jersey. Motion seconded and carried.

Dr. Justin moved that the Society send a resolution to Hudson County representatives in the Legislature, at Trenton, objecting to the proposal for a new revenue tax bill in which professional men are to be further taxed. Seconded and carried. An amendment was adopted—that notice of this resolution be sent to the other County Medical Societies, that the matter be handled through the Welfare Committee, and that coöperation of the Bar, Dental, and Druggist Associations also be sought.

Dr. Schwarz moved that the Delegates recommend to the State Society the creation of an Honorary Membership for older physicians (in practice more than 40 years) allowing all the rights and privileges of full active membership, including receipt of the Journal, without the payment of any dues. This was amended to read "Life Members", instead of Honorary Members, and the motion was carried.

Drs. Edwin R. Core and G. Thomas De Fusco were elected as new members.

The "Election Committee", to serve in October 1933, was elected and consists of Drs. Conty, Doody, Dougherty, Hammer, Meehan, S. G. Scott, and M. Shapiro.

Special Meeting

A "special meeting" of the Hudson County Medical Society was held on Friday, May 12, 4.20 p. m., to consider the subject of "Coöperation Between the Medical Society and the Emergency Relief Administration" on the question of "partial compensation of physicians for the care of indigents".

Dr. D'Acierno presented the following Report of Investigation Committee: "The Committee appointed by you to investigate and report on the recommendation of the National Committee on the Costs of Medical Care has fully endorsed one of the most important Recommendations of the Minority Committee on the Costs of Medical Care; that is, that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed, as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession. Now, the proposal of the State Emergency Relief Administration, to compensate the medical profession for medical care of indigents, falls within the realm of such a large political institution as the State and therefore conflicts with the expressed opinion of your committee, and in general with the sentiment of the rank and file of members in our Society. Furthermore, the above proposition is objectionable for the following reasons:

(1) It would add another heavy burden to the hard pressed tax payers of this State.

(2) Wou'd lower the morale and standards of medical practice, which eventually would be dictated by body politics.

(3) Would disrupt the personal contact between physician and patient.

(4) Wou'd tend to pauperize the so-called white-collar class.

(5) Would stimulate, above all measure, the abuse of free medical service.

(6) Would put in jeopardy the earning capacity of younger physicians when confronted with the competition of the older physicians.

(7) Would lead to formation of a political, medical racket.

(8) A similar plan in Bergen County is a failure on account of red tape, and lower professional prestige.

For the above reasons, I make the following motion: 'That the Hudson County Medical Society shall go on record as rejecting the proposal, as being uncalled for, vicious in its potentialities, and unwarranted by the experience of these communities.'

The following amendment was offered: 'That the Hudson County Medical Society is not opposed to coöperating with the E. R. A. in the care of indigents, but is opposed locally to the *principle* of accepting remuneration from the E. R. A. for the care of its clients.' We recommend to the State Medical Society that 'the proposal of the E. R. A. be handled separately to suit each county's need, and further advise, that we are whole-heartedly in support of emergency relief for the indigent, but refuse acceptance of fee fixing schedules for persons deserving medical charity.'" The amendment and motions were adopted.

Dr. Chapman suggested the following safeguard.

(1) Complete administrative control of patients must be in the hands of the medical profession.

(2) No interference with free choice of physicians.

(3) The medical profession alone shall decide when the emergency shall cease.

(4) The schedule of fees shall establish no precedent.

(5) The medical profession reserves the right to abrogate this agreement at any time.

(6) Patient has the right to choose own hospital.

(7) Medical profession does not have to certify as to disability or illness under this plan.

He felt that the State, however, should supply the material necessities.

The opinion was expressed that the beneficiaries of this proposal might be the municipal and other hospitals which would charge the E. R. A. for medical services which the doctors gave free, the money going to the hospitals, and the doctors, as usual, being left out in the cold.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The Mercer County Medical Society held a regular meeting on May 11, at Peddie School, Hightstown, in acceptance of an invitation extended through the courtesy of Dr. R. W. Swetland, Headmaster of the School.

Following a round of golf, about 65 members sat down to a most delicious dinner, served in the dining room of the School, after which Dr. Wilbur, in the absence of Dr. Proctor, the President, introduced Dr. Swetland, who gave a very interesting account of the early history of the Institution and its progressive steps toward the present high standard.

A letter from Dr. Cosgrove, Chairman of the State Society's Committee on Hospitals and Medical Education, was read and the motion carried that our present Committee on Post-Graduate Courses be retained in office as a hold-over committee.

The applications of Drs. E. G. Meriwether and A. E. Ogden were read and referred to the Membership Committee.

Following the reading, by the Secretary, of a communication from Dr. J. A. Fisher, relative to the "Proposals to partially compensate physicians for services through the Emergency Relief Administration", a lively discussion took place; being opened by Councilor F. G. Scammell, who described at length the proposed undertaking.

Varied opinions were expressed by different members and discussion was followed by the motion, made by Dr. T. A. Pierson, of Hopewell, and seconded by Dr. Scammell, that we should go on record as approving the action of the Special Committee, appointed by the Board of Trustees, relative to this subject. There were 21 members in favor and 14 against the motion.

Dr. Blaugrund announced that the Program Committee had practically completed arrangements for the "Summer Outing" of the Society to be held at the Hopewell Valley Golf Club on June 15, final notices to be sent out in the near future.

MIDDLESEX COUNTY

Medical Section of Rutgers Club

J. H. Rowland, M.D., Secretary

The regular monthly meeting of the Medical Section of the Rutgers Club was held on Friday evening, April 28, at 9 p. m., at the Alumni House, Queen's Campus, Rutgers University, with Dr. Howley presiding. Those present were: Drs. Brody, Cronk, Faulkingham, Feher, Gutmann, Haywood, Howley, Johnson, Karshmer, Kler, Leonard, Merrill, McGovern, Nafey, Rothschild, Rowland, Runyon, Sherman, Sullivan, Toy and Avery.

There being no business to transact, the speaker of the evening, Dr. Lee M. Hurd, Professor of Otolaryngology at New York University, was introduced and talked about "Asthma and Other Allergic Conditions". The talk was illustrated by radiographs, lantern slides, and case reports, and the subject was freely discussed by our members.

MONMOUTH COUNTY

R. A. Mackenzie, M.D., Reporter

Following the custom initiated last year, of meeting alternately at each of the 2 hospitals in Monmouth County, the regular April meeting of the Monmouth County Medical Society was held at the Monmouth Memorial Hospital, in Long Branch, on the evening of April 26. The President, Dr. Robert E. Watkins, called the meeting to order, with 46 members present. Considerable discussion followed the Secretary's reading of a letter from the Welfare Committee of the Medical Society of New Jersey regarding proposals sub-

mitted by the State Emergency Relief Administration to compensate physicians for the medical care of Emergency Relief Administration clients. It was then voted to accept the recommendations of the Welfare Committee, and of the Special Committee appointed by the Board of Trustees, and to coöperate in whatever plan may be formulated to take care of this important matter, with the provision that the plan be put into effect for a period of not more than 1 year.

At a meeting of the Executive Committee of the Monmouth County Society, held on April 17, Dr. Stanley Nichols, Chairman of the Public Relations Committee, had brought up the matter of the increasing demands made upon physicians to take care of the indigent sick, and had suggested the formation of a Monmouth County Health Service Committee, to include all health agencies in the county, to work out a solution of this problem. A resolution was formulated, as follows: "As its contribution to betterment of the Public Health, the Monmouth County Medical Society, through its members, offers to make an agreement with any municipality in Monmouth County to care for the indigent sick at ½ the usual minimum rates for such service, the expense to be borne by the municipality." This resolution was not submitted to the regular meeting of the Monmouth County Medical Society because the letter from the Welfare Committee seemed to make such action unnecessary.

The application of Dr. Alfred Cole Wallin for membership, having been favorably reported by the Censors, was approved.

Dr. Raoul Pietri, Attending Neurologic Surgeon to both the Monmouth Memorial and Fitkin Memorial Hospitals, presented a very interesting paper entitled: "Diagnosis and Treatment of Intracranial Injuries." Because of the fact that publication of this paper in the Journal of the Medical Society of New Jersey is anticipated, no summary of the material presented is here attempted.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the Morris County Medical Society was held on the evening of May 4, in the State Hospital at Greystone Park, with President Pinckney presiding over an attendance of about 40 members. The call was to consider the proposals of the State Emergency Relief Administration to compensate the medical profession for medical care of Emergency Relief clients.

Discussion of the subject was quite general and thorough. The voice of the members was unanimous for coöperation, during a discussion which dwelt mainly upon methods and safeguards, and the unanimous action taken was, as follows: "The Morris County Medical Society concurs in principle with the recommendation of the State Society's Welfare Committee; with the understanding that it runs for but 1 year; (2) and with the further understanding that free choice be allowed the patient in the selection of physician; (3) that the administration in the county be left to the Committee of the County Society; (4) and that we believe the fees stated, $1, $2, and $25 shall be the minimum.

Pending legislation was discussed, in which Dr. Costello took a leading part. Members were urged to appear in opposition to the named Bills and unanimous action was taken that the Secretary write to Morris County Legislators—Senator Young and Assembly Members Mutchler and King—expressing the opposition of the County Society to the passage of S-226, S-312 and S-313.

After disposing of the business at hand the members enjoyed refreshments in the hospital cafeteria.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

A well-attended Special Meeting of the Society was held at the Elizabeth General Hospital on the evening of May 3, with Dr. Emil Stein presiding. The purpose was to consider proposals from the State Emergency Relief Administration to partially compensate physicians for the medical care of Emergency Relief Administration clients.

Dr. James S. Green, Trustee and an Ex-President of the State Society, ably presented the proposal and explained it in detail. He was followed by Dr. Charles H. Schlichter, Chairman of the State Society's Welfare Committee, who amplified Dr. Green's remarks. Both answered questions from the audience, clearing up doubtful points. Full discussion followed and more than a score of our members voiced their opinions. Finally, the Society accepted the proposals, *in principle*, by a practically unanimous vote, leaving to the able Committee in charge discretion to approving details.

Before adjourning, the Secretary was instructed to send a telegram to Senator Loizeaux, requesting him to vote against the vicious "Osteopathy Bill" No. S-226; and our members were urged to appear at the hearing in the State House to protest personally against its passage.

Obituaries

COTTON, Henry A., of Trenton, New Jersey, died on May 8, 1933, of a sudden attack of cardiac disease, at the age of 57. He had been in poor health for a year or more and was aware of his condition. A month ago, after several weeks' confinement in his home on the Lawrenceville-Princeton road, he resumed his daily habit of lunching at the Trenton Club. He had, on the fatal day, lunched there with several friends. They talked for a while after lunch until Dr. Cotton excused himself and went to the pantry, where he kept a bottle of medicine for such attacks. When a club attendant found him a few minutes later, lying dead on the floor, the bottle rested in his hand.

Dr. Cotton was born in Norfolk, Va., May 18, 1876. His family on both sides were residents of North Carolina from Colonial days and he was a direct descendant of Nathan Mayo, a member of the Continental Congress of North Carolina.

His maternal grandfather was Judge Asa Biggs, United States Senator from North Carolina and afterward Judge of the United States Court.

He received his early education in the public schools of Baltimore, and was graduated from the Baltimore Polytechnic Institute in 1894. For a year he studied electrical engineering at the Johns Hopkins University.

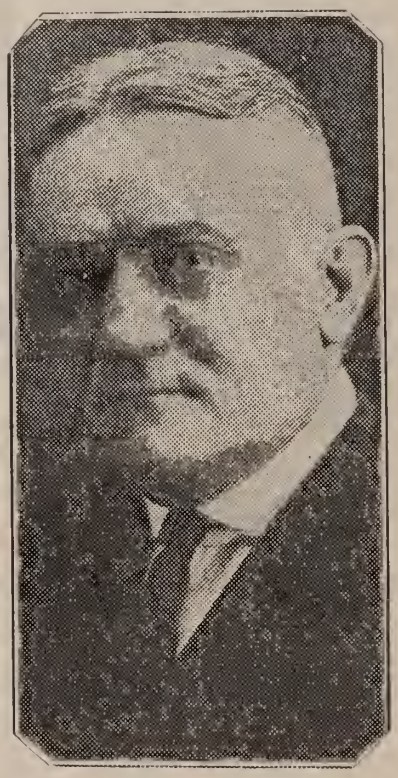
Dr. Cotton was also a student of the University of Maryland and St. John's College. Then he decided to study medicine and entered the Medical

School of the University of Baltimore. He was graduated in 1899.

His first position after leaving school was that of Counsel to the City Asylum at Bay View, Baltimore. From a year's experience in this institution came his interest in the care and cure of the insane.

A year after returning from his study abroad, Dr. Cotton was promoted to the post of Assistant Superintendent of the Danvers Hospital and in November, 1907, he was appointed Medical Director of the Trenton State Hospital.

His first step here was to abolish the mechanical restraint of patients and he introduced many modern facilities which transformed the asylum into an up-to-date State hospital. He succeeded in obtaining generous appropriations from the Legislature with which to carry on his splendid work.



HENRY A. COTTON

The present group of buildings stand as a memorial to his devoted labor.

His work consisted principally in demonstrating that so-called mental diseases have a physical basis, that they are the result of chronic infections existing in the teeth, tonsils, gastro-intestinal tract and other portions of the body, since these infections produce toxic products which in turn poison the brain tissue. Dr. Cotton's treatment consisted largely in eliminating these foci of chronic infection in the individual early in his course of treatment.

During the World War, Dr. Cotton served as a Major in the Medical Corps of the Army.

He was a lecturer in psychopathology at Princeton University, acting Director of the Psychiatric Clinic for correctional institutions of New Jersey and Acting Director of the Medicine and Psychiatry State Board of Institutions and Agencies of New Jersey.

He was affiliated also with the American Medical Association, the American Neurological Society, American Psychiatric Society, Corresponding member of the British Medico-Psychological Association, American Association for the Advancement of Science, Medical Society of New Jersey, former President of the Mercer County Medical Society, Philadelphia and New York Psychiatric Societies and the American Bacteriological Association.

Less than a month ago, the New Jersey Legislature adopted a resolution lauding Dr. Cotton's work. He was retired in 1930 as Active Director of the institution, being designated Director Emeritus.

High officials of the State Department of Institutions and Agencies repeatedly have declared that the Cotton methods were saving the State of New Jersey millions of dollars and bringing mental health to hundreds of unfortunates through the relatively high recovery rate made possible.

WILLIAMS, Irving Dewey, M.D., 60 years of age, a member of the Essex County Medical Society, and of the Academy of Medicine of Northern New Jersey, for a number of years, died April 7, 1933, at the Battle Creek Sanatorium, Michigan, where he had gone about 3 months previously for treatment of a condition due to Hodgkin's disease. He was a distant relative of Admiral Dewey, a native of Turin, New York, where he was interred on April 10, and lived in New York City for some time as Medical Director of the C. B. Town's Hospital for Drug Addiction, and the Central Park West Hospital.

Educated at Cazenovia Seminary, he graduated from Hamilton College in 1897 and received his degree of M.D. in 1903 from the College of Physicians and Surgeons, Columbia University, New York. He studied in Europe, then became the first resident physician and surgeon of the new French Hospital, New York, and later held medical licenses in Oregon, New Mexico, New York and New Jersey, and had connections with Post-Graduate, Roosevelt, New York, and Bellevue Hospitals, having also been General Superintendent of the New York City Tuberculosis Sanatorium at Otisville, New York. He was chosen by Admiral Peary for Surgeon on the North Pole expedition but his father's objections prevented his going; which caused him lasting regret.

He was a man of wide associations, a doctor of deep appreciation of his profession's obligations and privileges, a friend of sterling worth, a citizen of unflinching adherence to righteousness in public and private life, a member—active or honorary—in many societies (medical, social, civic and church), and a Free Mason.

The outstanding thing in Irving Dewey Williams was his high conception of righteous living and standing, always without flinching, for lofty ideals in individual and organization responsibilities. His 22 years of management as Superintendent of the C. B. Towns Hospital for Alcohol and Narcotic Addiction was a buttress in a private hospital for maintaining pure ethical standards and against mere commercialism. Our profession needs more such men as inspiration to the management of institutions on a lofty ethical plane.

(Signed) Frank W. Pinneo.

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WORK AS MEDICINE

(Newark Evening News)

For at least 10 years the deteriorating effects of unemployment on health and morale have been recognized in England. We are beginning to note similar conditions here. In the address of Dr. Parran, State Commissioner of Health, he gives a timely warning against relief without work. They have kept 2 million men alive in England, but character and physical strength have been so seriously undermined that many of them are now incapable of holding a job if work is found for them. Our unemployed have shown remarkable fortitude, but the effects of discouragement and inadequate diet are beginning to appear.

Dr. Parran reports that one person is 6 among families receiving home relief for a year is ill, and that only about half of these sick persons have received medical attention. Health Departments, charitable agencies and many private physicians have tried to help such patients. but it is evident that they are not covering the ground. Social agencies have done their best to help mothers make the "relief" diets stretch to meet the needs of families of adults and children, but Dr. Parran affirms that "even for the well" they provide too narrow a margin for the needs of adults or growing children.

On the mental side results are equally disastrous. The typical head of a family receiving home relief has been out of work for nearly 2 years and has been getting help for nearly one. He has almost given up looking for work. His wife is beginning to feel that they are beaten. His loss of initiative is reflected in her disheartened management of the home. The children have an example of helplessness in their parents. They do not realize fully that the security which should be theirs is not being provided, but they know that something is missing in their lives. That sturdy self-reliance which has for so long been characteristic of the American workingman is beginning to weaken. Any kind of work, even if it brought in no more than the insufficient relief of charity, would be better than bare existence.

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ESSEX MEN NAMED TO FACULTY OF N. Y. U.

Announcement has been made by New York University of additions to its faculty. Appointments have gone to Dr. Harrison G. Martland, Essex County medical examiner, as associate professor of forensic medicine at the Medical College, and Dr. Stuart Zeh Hawkes, son of Dr. E. Zeh Hawkes of Newark, who has been named assistant in surgery.

Other appointees include J. F. O'Neill of Irvington, assistant in chemistry at the College of Arts and Pure Science; Dr. Clifford G. Weston of Glen Ridge, assistant in medicine, and Dr. Raymond N. Allen of Orange, assistant in surgery.

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HOSPITAL AT SOHO TREATED OVER 1000 CASES LAST MONTH

(Newark Sunday Call, April 9)

A record was established last month at the Essex County Isolation Hospital. More than 1000 patients were treated, 573 of whom were admitted for periods of a week or longer. Dr. Eliis L. Smith, superintendent, said that the large number of patients was partly attributable to the minor epidemic of scarlet fever, of which there were 163 cases reported, and a larger one of measles, with 203 cases. He pointed out that there has been a marked drop in dipththeria cases, only 7 of which were admitted to the hospital last month, the lowest number in years.

Freeholder Lehmann, chairman of the Isolation Hospital Committee, said that no other similar institution in this country is equipped with more efficacious facilities for preventing the the spread of disease, and that the Soho Hospital has long since outlived the reputation it once earned of being "pest house."

"Parents, who formerly hesitated sending children to the hospital, now do so confidently," he observed. "The hospital population is increasing steadily, with 25,133 patient days the first quarter of this year as compared with 17,799 for a similar period last year."

Besides measles and diphtheria, the largest number of cases at the hospital are of erysipelas, of which there were 47 admissions. Next, in the order of their number; Chicken pox, 28; obsolescent scarlet fever, 17; mumps, 16; vaginitis, 10; septic throat, 7, and all other diseases 1 or 2 cases each.

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As pointed out by Dr. James A. Tobey in a recent scientific article (Archives of Pediatrics, March, 1933), approximately 2800 babies have been included since 1929 in more than a dozen independent clinical investigations on the use of evaporated milk. No adverse findings were reported by any of these observers, who employed evaporated milk for prematures and the new-born, for marasmic infants, and for the routine feeding of normal, well babies. In all instances good results were obtained.

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FINDS THIN PERSONS HAVE LONGEST LIVES

(New York Times, April 7)

The underweight individual apparently has a better chance to live longer than the so-called normal or ideal weight person, and evidence is accumulating that the popular weight standards for the best health are apparently too high, the New York Academy of Medicine was told by Dr. Herman O. Mosenthal of New York, in the eighth Hermann Michael Biggs Memorial Lecture. Dr. Mosenthal spoke on the present-day problems of diabetes treatment.

The rising mortality rate in diabetes, cancer, cardiac, arterial and renal diseases, Dr. Mosenthal added, is associated, according to statistical evidence, with overweight, which in turn is increasing as a result of faulty habits of diet, lack of exercise and sedentary habits. Every degenerative disease gives evidence that obesity has a very adverse influence on the life of human beings.

Statistics show, Dr. Mosenthal said, that the use of insulin has resulted in a drop during the period from 1900 to 1930 of about 50 per cent in the diabetes deaths due to coma. On the other hand, diabetics are still susceptible to bacterial infections, gangrene, cardiovascular condition and renal diseases, and deaths attributed to these causes have shown a rise of 35 per cent in the period from 1900 to 1930.

"At the present time," Dr. Mosenthal continued, "about 2000 diabetes deaths are registered annually in New York City. The diabetes death rate is about 50 per cent higher than it was 20 years ago. These facts call for some remedial effort.

"A distinct rise in the number of diabetes deaths is occurring, not only in New York City, but throughout the United States, as shown by the mortality statistics from other cities.

"Diabetics should not die of diabetes. The methods and objectives of diabetes treatment available today are adequate to accomplish this. They are not as universally applied as they should be."

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At least 80% of the illnesses that occur and practically all of the preventive measures employed are quite within the knowledge and skill of a competent and properly trained practitioner. The specialist is a consultant whose services are relatively rarely required and then usually on the advice of the family physician, who knows when the greater knowledge or skill is essential and where it can be found. As one should not complain about the high cost of thimbles if one insists on purchasing them in a jewelry shop, so there should be but little sympathy over the financial burden of one who employs a specialist to treat a cold and much less for him who periodically subjects his anatomy to a search for the trivial by a battery of highly trained and expensively equipped specialists.—Harvey, S. C.: Oikonomia Medika, Yale J. Biol. & Med. 5:323 (March) 1933.

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HOW TO KILL A MEDICAL SOCIETY

Don't come to the meetings. If you do come, come late. If the weather doesn't suit you, don't think of coming. If you do attend a meeting, find fault with the work of the officers and other members. Never accept office, as it is easier to criticize than to do things. Nevertheless, get sore if you are not appointed to a committee; but if you are, do not attend the committee meetings.

If asked by the Chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting, tell everyone how things ought to be done. Do nothing more than is absolutely necessary, but when other members roll up their sleeves and willingly and unselfishly use their ability to help matters along, howl that the organization is being run by a clique.—Delaware State Medical Journal.

Thumbs Slightly Down

Children have their own peculiar way of expressing themselves.

"Well, Peggy", said the neighbor, "and how do you like your new governess?"

Peggy thought a moment and then said: "I half like her and I half don't like her, but I think I half don't like her the most."—Boston Transcript.

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Metabolic disorders will be the theme of the 1933 Graduate Fortnight of the New York Academy of Medicine. Two weeks of intensive study, from October 23 to November 3 inclusive, will be devoted to this important branch of medical science. The theoretical, physiologic and pathologic phases of Metabolism, as well as of certain of the associated endocrinologic problems, will be treated in a series of round table discussions and clinical demonstrations. The latter will be given in 15 of the leading hospitals of New York City.

Among the speakers who will participate in the Graduate Fortnight are included Drs. Eugene F. DuBois, Harold E. Himwich, Walter W. Palmer, Frank H. Lahey, Donald Dexter Van Slyke, Joseph C. Aub, Ashley Weech, Dana W. Atchley, Erwin Brand, Emanuel Libman, Rollin T. Woodyatt, Priscilla White, Nellis B. Foster, Herman O. Mosenthal, William S. Ladd, Henry W. Geyelin, Albert A. Epstein, John P. Peters, Henry C. Sherman, Samuel W. Clausen, Alfred F. Hess, Wilder G. Penfield, Oscar M. Schloss, Henry L. Jaffe and Charles F. Bodecker.

An exhibit will be shown in connection with the Fortnight, material having been collected from many institutions in Metropolitan New York. The various aspects of metabolic disorders will be covered in this exhibition, including the history of metabolism; dietary constituents and their derivatives; drug and other therapeutic measures; general and special pathologic metabolism; and laboratory methods and procedures.

The subjects will be illustrated by means of charts, grafts, photographs, microphotographs, transparancies, x-rays, gross and pathologic specimens.

The profession of the country is invited to participate in the Graduate Fortnight.

A complete program and registration blank may be secured by addressing Dr. Frederick P. Reynolds, the New York Academy of Medicine, 2 East 103rd Street, New York City.

CLERGYMAN HEADS HOSPITAL TRUSTEES

(Newark Evening News, May 5)

Rev. Charles L. Gomph, Rector of Grace Episcopal Church. was elected President of the Trustees of the Hospital of St. Barnabas at a meeting of the Trustees, filling the vacancy caused by the death of John B. Foster. The new President has been associated with the work of the hospital 20 years, having becn Chairman of the Executive Committee of the institution prior to its merger with the Hospital for Women and Children.

Drs. E. J. Ill, Charles L. Ill and H. B. Vail, all emeritus members and former Presidents of the Medical Staff of the hospital, were elected members of the Board of Trustees. The Trustecs confirmed the recent appointment of John G. Martin as General Superintendent of the hospital. Miss Alma M. Viehdorfer continues as Superintendent of the Central Avenue Branch.

STAFF OF CITY HOSPITAL HOLDS ANNUAL MEETING

(Newark Evening News, May 5)

The work accomplished by Newark City Hospital was discussed at the Annual Staff Meeting of that institution. A business session preceded the discussion, which was held in the Nurses' Home.



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OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 7 Orange, N. J., July, 1933 Subscription, $3.00 Per Year
Single Copies, 30 Cents

THE N.Y. ACADEMY OF MEDICINE
JUL 11 1933
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For Enteritis

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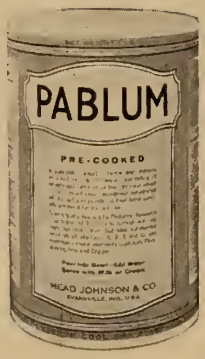
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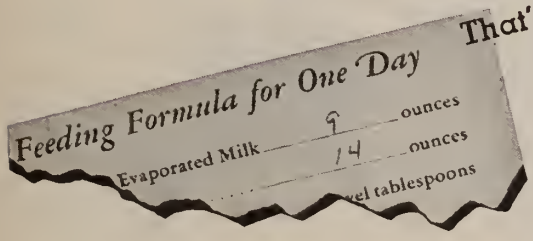
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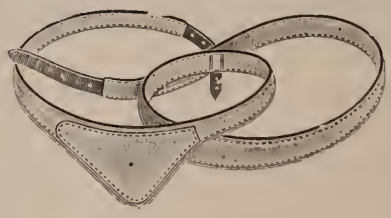


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N. Y. U. WILL TRAIN DOCTORS IN SCIENTIFIC CRIME DETECTION

New York University, through Chancellor Elmer Ellsworth Brown, announced the establishment of a department of Forensic Medicine at the University and Bellevue Hospital Medical College, to train medical examiners and toxicologists.

The new department, one of the first of its kind in this country, was hailed by Dean John Wyckoff of the Medical College as an initial step towards establishing a system of scientific crime detection in this country which may some day rank with the system of medico-legal institutes of continental Europe.

Dr. Charles Norris, Chief Medical Examiner of the City of New York, has been named Professor of Forensic Medicine and will head the new department. Dr. Harrison Martland, Chief Medical Examiner of Essex County, N. J., (Newark) has been appointed Associate Professor of Forensic Medicine.

Other members of the departmental faculty will include Dr. Alexander O. Gettler, City Toxicologist, who will become Professor of Toxicology; Dr. Douglas Symmers, Director of Laboratories at Bellevue Hospital, who will be professor of Gross Pathology.

OFFICIALS, OTHERS PAY TRIBUTE TO DR. W. W. ARESON AT MONTCLAIR

(Newark Evening News, June 16)

Tribute was paid to Dr. William H. Areson, Montclair Director of Health, at a dinner at Montclair Golf Club at which Senator Wolber, Mayor Oscar L. Carlson and a number of prominent medical men of the county told of the achievements of the honor guest during his 26 years of service in the vicinity.

Dr. James T. Hanan, Chairman and Toastmaster, outlined Dr. Areson's work in Montclair after his graduation from Columbia University College of Physicians and Surgeons in 1896.

After serving as an interne at St. Joseph's Hospital, Paterson, for a year, Dr. Areson went to Montclair the next year and began practicing. In 1917 he was among the first to volunteer for war service and was placed in charge of a hospital.

After the war Dr. Areson was Chairman of the Montclair Veterans' War Memorial Commission. He served as head of the Medical Advisory Board of the Board of Freeholders in the reorganization of the Essex County Isolation Hospital. He was President of the Montclair Board of Health many years.

Today he is Consulting Surgeon of the 3 county hospitals, Overbrook, Essex Mountain and Essex County Isolation. He also is President of the Essex County Medical Society.

Mayor Carlson paid tribute to Dr. Areson in declaring Montclair has one of the best health departments in the State.

Dr. V. B. Seidler, Vice-President, in the absence of Dr. F. Elmore Hubbard, President, spoke for the Staff of Mountainside Hospital.

County Supervisor Ernest A. Reed lauded the honor guest and said the benefits of his accomplishments would be felt in Montclair for many years.

"Most people think of a doctor as a recluse and a scientist", Senator Wolber said. "They are supposed to keep far from the 'maddening crowd', but, instead, Dr. Areson has contributed to the protection of the public health of the community as well as fulfilling all his duties as a citizen."

Dr. Frederic Quigley, President of the State Medical Society, and Commissioner Howard F. McConnell also spoke.

Dr. L. W. Halsey presented an illuminated scroll signed by the 90 guests present to Dr. Areson.

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PHARMACISTS PICK OFFICERS AT SHORE

(Newark Evening News, June 17)

The New Jersey Pharmaceutical Association at its concluding business session at the Berkeley-Carteret Hotel gave unanimous consent to the recommendation of its President pledging support to the efforts of President Roosevelt and Governor Moore to improve the economic situation.

The Resolutions Committee was upheld in disapproving a recommendation to bar the Association from holding annual meetings outside New Jersey. Another recommendation directing that members in arrears in dues could be brought up to date by payment of a year's assessment was amended to allow 2 years' arrearages before suspension instead of 1, as recommended by President Henry D. Kehr, of Trenton.

The recommendation sponsoring organization of a council of county Delegates was laid over for a year for further action. The association approved a recommendation permitting the President to appoint a committee of 3 to act in an advisory capacity to the State Emergency Relief Administration.

A special resolution indorsed Governor Moore's appropriation recommendation for Rutgers University. Dr. Ernest Little, Dean of the Rutgers College of Pharmacy, declared Rutgers had suffered a 44% reduction.

Walter R. Woolley, proprietor of the Monterey Pharmacy, Asbury Park, was unanimously elected President of the Association to succeed Kehr. Others elected are: First Vice-President, William H. Tegeler, Camden; Second Vice-President, William R. Riker, Elizabeth; Secretary, Prescott R. Loveland, Atlantic City; and Treasurer, Charles J. McCluskey, Culver's Lake; Trustees for 3 years, Kehr and William G. A. Kroemmelbein, of Trenton; Committee on Public Welfare, Charles H. Jackson and William J. Korbonits, Asbury Park.

The 3 days' convention closed last night at a banquet in the Berkeley-Carteret Hotel. Dr. Robert L. Swain, President-Elect of the American Pharmaceutical Association, spoke and the officers were installed.

DR. SAUL ADLER HONORED

(New York Times, June 11)

Dr. Saul Adler, Professor of Parasitology at the Hebrew University in Palestine, will receive the Chalmers Gold Medal of the Royal Society of Tropical Medicine and Hygiene of England at the Annual Meeting in London of the Society's Council. This was announced June 10 by Dr. A. S. W. Rosenbach, President of the American Friends of the Hebrew University.

The medal has been awarded to Dr. Adler in recognition of his work as Director of the Kala-Azar Commission of the Royal Society in 1930-32. In that capacity he did research work in kala-azar, a virulent disease, in Italy and Malta under the joint auspices of the university and the society. Earlier this year a Laveran Medal was awarded to him by the Société de Pathologie Exotique for the same research work. He is 38 years old.

Dr. Rosenbach announced also that Dr. Chaim Weizmann, President of the university, had established the Daniel Sieff Research Studentship in the Department of Parasitology, providing £200 annually for research work under the general supervision of Dr. Adler.

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LOWELL SEES CHILD RETARDED IN MIND

(New York Times, June 3)

Dr. A. Lawrence Lowell, President of Harvard University, said that care for the American child's physical welfare has retarded his mental development. Dr. Lowell spoke at the dedication of the 170-acre Morris Arboretum of the University of Pennsylvania.

Schoolboys of this country are, "as a rule, less advanced" than those of Europe, he said.

"They begin later and progress more slowly. The physicians have been in part responsible for this, for they have been constantly advising parents not to send their children to school too young, and not to press them too hard when they get there."

Much of what is important in later education—habits of close attention, of rapid reading, of accuracy and others—"are best acquired before the age of 10", he asserted.

"Solid reading for pleasure or self-improvement has fallen too much into neglect", he went on. "This is certainly not because the ordinary college student works too hard at other intellectual pursuits.

The greatest benefits of college life are not spectacular or adapted for current publications", he asserted, adding that "students, as a rule, have a better appreciation of the relative value of scholarship and athletic victories than the public at large."

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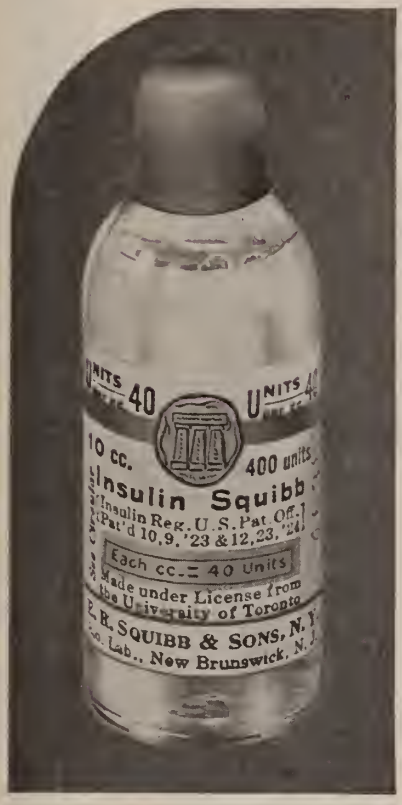
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* Dr. Charles Bolduan, *New England Journal of Medicine*, 7-14-32.



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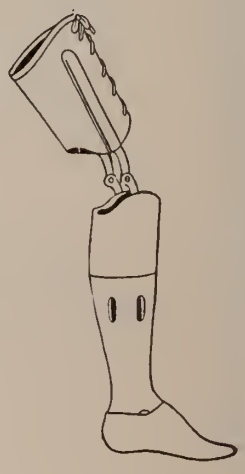
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PRESIDENTIAL ADDRESS*

A. Haines Lippincott, M.D.,
Camden, N. J.

This, the oldest medical society in the United States, merits for its President a more able representative of our great profession than I claim to be. But, in spite of the fact that this high office was not of my seeking. you elected me and have yourselves only to blame.

I feel honored by this exalted position. I have to the best of my ability carried on the duties of the office; and through contacts with my colleagues have developed a deeper interest in the activities of the medical profession as carried on through the component societies.

The office of President of the Medical Society of New Jersey is indeed an honorable one; and although the duties, if conscientiously performed, require a considerable portion of one's time, yet the recollection of this year of my life, when I have been privileged to serve my profession in this capacity, will be lasting and satisfying.

I have endeavored to visit as many of the component societies as possible, but, still being engaged in the practice of my chosen profession, much to my regret it has been impossible to visit all the units. I have made a special effort to visit group meetings, such as the Councilor District Meetings and the Conference of County Society Secretaries and Reporters, thus embracing several counties at the same time. I have enjoyed these visits immensely; the acquaintances I have made have enriched me; they have given me a greater love and understanding of my brother practitioners, and I have been able to comprehend more fully the problems facing the medical profession in these days of unusual conflict.

It is with a sense of deep gratitude that I acknowledge the valuable assistance of the 3 Vice-Presidents in relieving me of some of the visitations. Especially am I grateful to Dr. Quigley, who so graciously covered the northern group of counties.

The pleasure of meeting with the members of the various State Society committees, and of taking an humble part in their deliberations, is greatly appreciated. The work accomplished by these committees during the course of a year is tremendous in its scope, for in these conferences are born the policies of the Society. We owe a great debt to the members who give their time and thought to formation of these policies.

It is my sad duty to note the passing of several members who were prominent in the Society. With sorrow I note the death of Dr. Thomas Jefferson Smith, of Bridgeton, who was President of the Society during 1896-1897. He passed on at the time this Society was in session June last, at the age of 91. In the death of Dr. Martin W. Reddan, of Trenton, this Society lost a faithful and hard-working member. Dr. Reddan died during March of this year. For many years he was Chairman of the Committee on Program and Arrangements. His indefatigable attention to details made our Annual Meetings suc-

*(Delivered at the 167th Annual Meeting of the Medical Society of New Jersey, at Haddon Hall, Atlantic City, June 7, 1933.)

cessful. Dr. Emanuel D. Newman, of Newark, died in November, 1932. Prominent in his profession, Dr. Newman will be missed from our meetings because he was such a regular attendant. Dr. William Gray Schauffler died on April 30, aged 69. He was President of this Society in 1919, and to the time of his passing was one of its most sane and able counselors. Early in his career he went to Syria as a medical missionary. He was a professor in the Medical Department of the American University in Beirut, in that country. From 1911 to 1917 he was Surgeon General of New Jersey. He was Lieutenant Colonel during the World War. He had been a general practitioner of medicine in Princeton since the War. This Society also mourns the loss of a beloved and valued member, Dr. Henry A. Cotton, who died suddenly on May 8. Dr. Cotton was known internationally as an able alienist, and for 20 years he was Medical Director of the Trenton State Hospital for the Insane. He was called upon to give expert testimony in many famous murder trials. A pioneer in the thought that focal infection played an important part in cases of mental disturbances, his convictions led him into many controversies with his brother psychiatrists; and to his credit let it be said, he advanced many convincing facts.

My first official visit was made in September, when I had the pleasure of attending the Twenty-fifth Anniversary of the opening of the State Sanatorium at Glen Gardner. This wonderful institution, nestling in the hills of Hunterdon County, so ably directed by Dr. English, is a pride and credit to the profession of the State.

The officers of our Society and representatives from the various medical institutions of the State were in conference with the members of the Princeton Survey Commission appointed by the Governor. The object of this Conference was to discuss the economic relations of the various State institutions and medical boards receiving appropriations from the State.

This Society was honored in having our Executive Secretary, Dr. Henry O. Reik, chosen as 1 of 3 distinguished members of the medical profession in the United States, as an Official Delegate to the Centennial of the British Medical Association held in London, England, last July.

Dr. Walt P. Conaway, of Atlantic City, attended the Pan-American Medical Congress in Dallas, Texas, March 21-26, as a Delegate from this Society.

In my visits about the State, I have been greatly impressed with the earnest efforts on the part of physicians to improve their knowledge of disease in all its branches. This is an indication of a love for their profession and an urge for better mental equipment. The enrolment of our members in the Post-Graduate Courses during these times of curtailed income is proof of this. Economic reasons necessitated some changes in the plans of those courses conducted through the Educational Extension Division of Rutgers University, and so ably directed by Dr. Cosgrove's Committee during this year—namely, a reduction in fees and in the number of lectures to be given in each course. Due to the fact that the doctors' incomes have been markedly reduced, the enrolment fell off, as was to be expected.

The chief function of the Welfare Committee is to safeguard the public and the profession in the matter of legislation. As a member of this Committee from Camden County since its organization, and its Chairman for 3 years, I have had opportunity to note the fealty of its members. On several occasions I have paid my respect to the faithful and self-sacrificing service of this group. At the call of its able Chairman, Dr. Schlichter, these doctors journey almost 100% from all sections of the State to Trenton on Sunday afternoons. That they do this willingly on a day and at an hour when they might rest at home with their families, is an indication of their interest in matters concerning our Society and in the protection of the health of the people of the State.

We are all familiar with the reasons for the development of a plan for the control, regulation or certification of those desiring to specialize in some of the branches of medicine, and to practice as specialists. There have been several attempts to do this through legislation, but because such Bills, as drawn up,

were objectionable, the Welfare Committee felt compelled to oppose such legislation. My distinguished predecessor in this office, Dr. Hagerty, was Chairman of a Special Committee to study this question, and after conscientious consideration, the proposed legislation was reported inadequate to meet the situation. Everyone felt the need of some regulation but realized it was not a question for politicians to decide. It was our responsibility, and so this House of Delegates last year endorsed the Water's plan as further developed through conferences held by Dr. Hagerty. Every supporter of this plan is openminded, and knows that to be effective it should have the undivided endorsement of the physicians of the State, and that it should be able to withstand destructive criticism. If anyone has something better to suggest, tell us about it, for we must take some action. To quote from the final report of the Committee on Medical Education: "The specialist is an essential element in the modern practice of medicine. Only those who have had a thorough training should be permitted to practice as experts in a limited field, however. A Register of specialists or some other method should be created in each State, which will provide the public with information regarding those who have a suitable preparation in each field of practice."

With the exception of the time when Dr. Henry B. Costill, of Trenton, was Medical Director of the State Board of Health, never has there been such close coöperation between that Board and the medical profession of New Jersey as there is today. We, of Camden County, are proud of the fact that Dr. J. Lynn Mahaffey now holds this position. Dr. Mahaffey, a family doctor of many years' experience gleaned from a large clientele, brings to this important position a mind rich in medical facts and keen in solving problems of sanitation. He has attended regularly the meetings of the Welfare Committee, and has brought to that Committee medical problems that have come before the Board of Health, and has asked for counsel and advice. The position of Medical Director is almost a full-time one, and Dr. Mahaffey has accepted its duties to the detriment of his practice and his many home-town activities. This Society should be proud of Dr. Mahaffey, for he is a hard-working, faithful, under-paid State official, gracing a very responsible position.

I am impressed with the valuable work of the Field Secretary, Mrs. Taneyhill. Her lectures are of great benefit to the profession. She is spreading a gospel of health among lay groups which we as physicians could never reach. I have received many letters of commendation from all parts of the State, thanking this Society for sending her and requesting the privilege of scheduling her in their program if she is available next year. I feel sure this work is well worth continuing.

I have been always a supporter of the Woman's Auxiliary. Since its organization, the Auxiliary has exhibited an interest in the medical profession never before shown by women members of our families. Auxiliary members have been stimulated to study medical subjects; this gives them a closer contact and better understanding of our problems. With such better knowledge, they are equipped to debate for our side in their clubs, at luncheons, teas, and in many other social activities, where they are constantly hearing medical subjects discussed from the layman's point of view. The Auxiliary in this State, under the able leadership of Mrs. Charles Franklin Adams, its President, is well organized and holds interesting and well attended meetings which are attracting leaders in other women's groups. Card parties are giving way to educational programs. They are taking an interest in civic questions; in the distribution of Hygeia, a valuable and interesting magazine, especially edited for the laity, which should be on the news-stands and on every doctor's waiting-room table; in the endorsement of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey; and in many other subjects close to our hearts and profession. Their enthusiasm, interest and success depend upon us; they look to us for encouragement. Let us not fail them.

Many of us recall our State Journal of a few years ago, before arrangements were made to employ Dr. Reik as its Editor. Compare those issues with what comes to our desks today. Under the able editorship of Dr.

Reik, we have a Journal of which we are proud; one that compares favorably with any State Journal in the country. I wish to mention especially the January and April numbers of this year, dealing with the economic questions that confront the profession today. Dr. Reik's abstract of the "Final Report of the Committee on the Costs of Medical Care" is a masterpiece. This abstract has put into our hands *a brief* that will aid us in the formation of opinions on this subject, whereas otherwise days of reading would have been required to obtain the same information. I hope this Society will be always in the position to maintain our Journal on the high plane it has achieved.

In this brief address I may mention only a few of the activities of this Society during the past year; namely, the antidiphtheria campaign; extensive tuberculosis educational work; the Tri-State Medical Conferences that have done so much in bringing together 3 great adjoining States in an intimate and friendly understanding; Dr. Ireland's comprehensive school physicians' program; maternal welfare work; the effort on the part of this Society to join with the legal profession in asking the courts to appoint medical expert witnesses; the arduous work of the committee appointed to consider a uniform narcotic law; and a plan to formulate rules and regulations for the medical care of indigents, whereby the doctor will be paid for his services.

For some years there has been an agitation for our Society to own its home. I am heartily in favor of this if it can be financed, but think it should be centrally located and built to house a library and museum, with ample provision for committee meetings.

I feel there should be some action in the line of censorship for radio broadcasting of quack medical programs, and indiscriminate recommendations of proprietary preparations. The nauseating material that penetrates our homes is an insult to the intellect of the American people. Dr. Reik presented this problem at one of the Tri-State Conferences several years ago, and a protest was made to the National Radio Corporation, but without effect. At a recent meeting of the Welfare Committee, Dr. Quigley brought it to our attention, and it seems to me this Society might petition the American Medical Association to take some action in this matter.

This House of Delegates will be asked to consider a matter that is of vital importance to the profession—something that will affect our established form of practice, our income and our independence. I refer to the "Final Report of the Committee on the Costs of Medical Care". Following the publication of this Report, your President sent a letter to the Secretary of each County Society requesting that a Committee be appointed to study this subject. It is heartening to hear of the serious and thorough manner in which the component societies have considered this Report, and I feel that something really tangible will be presented to this House of Delegates.

Our profession from ancient times has had a code that has been our guide and has set forth our principles; and living under that influence, we have striven to elevate American standards of medical practice. The road is strewn with the corpses of our brethren who have sacrificed their health and lives in the realization of these standards and principles. But courage has been the watchword of our profession, and we have kept pace with progress in modern medicine, and have met every crisis with determination not only to protect our profession but to protect the public from a cold and standardized practice which would take from it all sympathy and friendliness.

No one chooses this profession with the idea that he will attain great riches, but rather with the thought that through the medium of medicine he can do the most for his fellowmen, and that it opens to him the road to an honorable career. There never has been a time when the true physician has not willingly given of his knowledge and strength to serve those stricken by disease. He has manned charity clinics and gone into homes to administer to the destitute without thought of profit, and he will continue to do so to the end of time. Realizing the sacrifices and accomplishments made by many in the field of medicine, it gives me a thrill to be able to say, "This is my profession."

It is with a sense of satisfaction that I recall to your memory the successful campaign of our parent society, the American Medical Association, through the Council of Medical Education and Hospitals, in ridding the country of the many diploma mills then in existence; in requiring medical colleges to conform to a certain standard, thus reducing the number of medical schools by 50%; and in adopting the plan of the American College of Surgeons to raise to a higher standard the hospitals of our country.

It may be true that more doctors are being graduated than are needed, and that they are not properly distributed, but doctors are better equipped to practice medicine than ever before. It may be true that there are people living in rural districts who receive inadequate medical care, but with the present means of transportation, this, I believe, is not so serious as it seems.

With a history of centuries of investigation, study, research, observation and deduction, our profession today towers above all other professions. The advances made in medicine during the past 100 years speak for themselves. Many men of our profession have been devoting their lives to scientific medical research that the world might profit; yet, in spite of all the advancement and benefit to the world thus derived, a radical departure from the traditional principles of the profession is proposed, and we are being urged to transplant ourselves into another atmosphere. If there was ever a time when medicine should be organized, it is now, in order to combat the proposals of highly financed lay groups. If there is to be a definite change in our present relations to our patients, let the doctors, not the politicians, say what this new arrangement shall be.

Quoting Sir William Osler: "Medicine arose out of a primal sympathy for man, out of a desire to help those in sorrow, need and distress." In reviewing the history of the medical profession, we find adequate proof of the altruism of physicians in their efforts to benefit the public.

I wish to refer you to an able historical sketch of the development of preventive medicine in this State, published in the Journal of October 1931, written by our Secretary, Dr. J. Bennett Morrison, in which he records the fact that from the birth of this Society in 1766 to date, its officers and members have, in the face of persistent opposition, mostly political, recommended legislative boards and commissions to safeguard the State against disease, to improve sanitation, to regulate the supervision of food, milk and potable water, to provide prophylactic measures against contagion, and to recommend the erection of institutions for the scientific care of those stricken with disease, both physical and mental. These battles of our illustrious predecessors are something for us to remember.

Specialization was unknown in those early days; our men were general practitioners; but from the general practitioner, the country doctor, whose mental equipment was developed by hard experience and deduction, have come some of the greatest benefits to mankind. Koch, discoverer of the germ of tuberculosis, was a country doctor in Prussia; Crawford W. Long, who first used ether as an anesthetic, was a country doctor in Georgia; Jenner, who instigated vaccination against smallpox, was a country doctor in England.

In the past century, great strides in civilization have been made. In comparison with material progress, medical achievements present the most enduring contribution to the age, and it is significant that through this period of economic depression, when things material have crashed about our heads, crushing to earth men who dealt in material things; when bankers, brokers and financiers have sought in death surcease of sorrow; when the calamities in the business world have been tragic; most of the men in the medical profession have gone steadily forward in the even tenor of their ways, unmindful of material losses, but considering and understanding the problems of human misery. Casualties among medical men, resulting from the present economic conflict, have been rare and exceptional.

Because of this nation's worship of material things, medical progress has had scant attention from the populace; but medical progress will endure beyond material things. Medicine gives us a sense of security which can be obtained from no other source.

Let us re-dedicate ourselves to our calling and to the traditions of our code. The doctor practices his profession in the light of present day knowledge. Any increase of medical knowledge does not benefit the physician primarily, it benefits mankind.

THE IRRITABLE BLADDER OF WOMEN

MEREDITH F. CAMPBELL, M.D., F.A.C.S.,
Urologist to the Babies' and the New York Nursery and Child's Hospitals; Assistant Attending Urologic Surgeon, Bellevue Hospital, New York; Director of Urology, Essex County Isolation Hospital,
Montclair, N. J.

Persistent urinary frequency and urgency, with or without dysuria or vesical pain, is an extremely common symptom-complex in females of all ages and usually leads to the diagnosis of chronic cystitis. In many of these cases the pathogenesis is obscure to external examination and the urinary findings are meager. Diagnosis of vesical neurosis or irritable bladder is often made. It is with this latter group that we are here concerned. The 4 most common chronic lesions causing this symptom-syndrome are discussed in the order of their etiologic incidence: (1) urethrotrigonitis, (2) urethral stricture, (3) ureteral stricture, and (4) submucous ulcer of the bladder. All are of frequent occurrence in women and all require careful urologic investigation in order to identify the underlying pathology. A review of the therapeutic methods necessary for control or cure of the lesions at once indicates the hopeless inadequacy of the customarily employed medical measures. Moreover, the therapeutic problems and disappointments in the urologic care of a series of only 6 or 8 of these patients will tax the ability of the urologist and maintain his humility.

It is important to note at the outset that for all clinical purposes primary cystitis is non-existent. The bladder infection is: (1) descending from the kidney; (2) ascending from the urethra; or (3) hematogenous (occasionally). Secondary involvement from an adjacent focus is rare. The usual acute inflammatory lesions of the bladder are associated with stone, tumor, diverticulum or acute urinary infection, and are regularly accompanied by marked pyuria. In these cases the vesical pathology harmonizes with the usual conception of cystitis. It is important to note that cystitis may be secondary to any urinary tract lesions and that careful examination will almost always reveal the etiologic pathology. The 4 common chronic lesions we are concerned with here may offer diagnostic difficulties because they are rarely manifested by marked urinary changes; pus, blood and bacteria are frequently scant or absent. In other words, the severity of the symptoms is disproportionate to the urinary findings.

URETHROTRIGONITIS

Urethrotrigonitis is an inflammation of the urethra and trigon; often only the anterior portion of the latter is involved.

Etiology. Although urethrotrigonitis is probably most often due to ascending infection, in many instances it is the lower tract expression of renal infection. It may follow the trauma of child birth, instrumentation, masturbation or intercourse, but usually appears spontaneously without apparent relation to lesions elsewhere. On the other hand, a low-grade unnoticed inflammation is frequently lighted up by the advent of acute focal or systemic disease, or congestion due to menstruation, exposure to cold, alcohol, sexual excitement, or constipation.

Pathology. The mucosal changes vary from a slight granular inflammation to marked edema or even ulceration. The slightest instrumental trauma is likely to cause bleeding. There is leukocytic infiltration of the urethral submucosa and, with an extensive process, the inflammation extends deep into the periurethral tissues and becomes the precursor of stricture. In acute disease the infiltrate contains many polymorphonuclears, but in chronic urethrotrigonitis small round cells and connective tissue increase dominate the histologic picture. The lesion is usually most marked in the posterior third of the urethra, and is more intense at the vesical outlet and adjacent tri-

gon than in the anterior canal. In the absence of renal infection, urinalysis in chronic urethrocystitis reveals only the products of superficial mucosal exudation, in which pus cells are relatively few but epithelial cells are numerous. With intense congestion or ulceration, red cells may be found. Bacteria will probably be seen.

Symptoms. The symptoms are usually proportionate to the acuteness of the disease, and in the order of their incidence are: frequency, urgency, dysuria, urethral pain and hematuria. The patient may void every 30 minutes day and night, although an hourly schedule is nearer the rule. With urgency, the imperative desire to urinate, many women wet their clothing before they can reach the toilet. Urgency indicates a marked inflammation of the anterior trigon and posterior urethra. Dysuria or difficult urination, when due to inflammation, is produced chiefly by reflex sphincterospasm. Pain is usually referred to the urethral meatus, but may be most pronounced in the perineum or suprapubic area. It may be a dull ache which, upon urination, becomes sharp and stabbing. Urethral spasm at the end of urination may cause painful tenesmus and an immediate repetition of the intense desire to void. Hematuria occurs with ulceration or marked congestion. With the latter, blood is actually squeezed from the congested mucosa when spastic sphincter closing occurs, and appears at the end of urination (terminal hematuria). Usually, the symptoms are characterized by an intermittency, and may be expected to increase in severity with the advent of infectious processes elsewhere or congestion locally (e. g., menstruation).

Diagnosis is suggested by the history but can accurately be made only by cysto-urethroscopic examination. Urinalysis may reveal scattered pus and blood cells, perhaps bacteria; always many desquamated epithelial cells. As a rule, the epithelial content is the most striking urinary finding. Cysto-urethroscopy is performed with least discomfort when No. 16 or 18 F. instrument is used. I commonly employ No. 18 F. McCarthy panendoscope. This instrumentation discloses an inflamed urethra and trigon. The lesion is most intense in the posterior canal, at the vesical orifice and over the anterior trigon. The posterior trigon and the remainder of the bladder wall usually appear surprisingly normal; as a rule, changes in the anterior urethra are less marked than elsewhere. The mucosal changes range from marked congestion to ulceration. Edema is usually found, and at the bladder neck edematous blebs are easily distinguished in profile. In chronic cases the mucosa may present a roughly granular congested appearance, often with small attached flakes of mucopus or epithelial desquamate. Occasionally one finds shallow superficial ulcerations covered with mucopus or showing a base of granulation tissue. In long-standing disease with mucosal infiltration, the trigonal and deep urethral surface appears grayish-red. The striking observation in most instances is the sharp localization of the inflammatory process; the bladder proper appearing normal.

Treatment. In acute urethrotrigonitis medical therapy is of value only as it may allay mucosal irritability. Urinary antiseptics here are of questionable value. Balsamics, hyocyamus or codeine preparations afford temporary relief, as may alkalinization of the urine. In chronic urethrotrigonitis, dilatation and application of silver nitrate are of specific value. Dilatation is most important because absorption of inflammatory infiltrate is encouraged. Dilatation achieved by passage of the catheter or cystoscope accounts for the improvement noted in these cases following vesical irrigation or cystoscopy.

Dilatation is best accomplished by passage of steel sounds, and the "natural-curve" instruments commonly used in males may be employed, although Hegar dilators or straight steel sounds are preferable. Urethral anesthesia renders the treatment less objectionable to the patient, and may be accomplished by injecting the urethra and bladder with 2-3 drams 10% novocaine hydrochloride. I commonly use 2% cocaine hydrochloride on a swab which is introduced the full length of the urethra. The swab is made by wrapping rather tightly a small quantity of cotton over nearly the length of a toothpick. As a rule, this may be passed easily if lubricated at the tip, and satisfactory anesthesia is usually obtained within 5 minutes.

The size of the sounds used depends upon the severity of the lesion. Generally, we can begin by passing a No. 20 or 22 F. instrument and progress at the first treatment as high as 26 F. Subsequent treatments should not be oftener than once a week and sometimes once in 10 days, at which time the first sound to be passed is slightly smaller than the sound last passed at the previous treatment. Periodic dilatation is thus carried on until the urethra is dilated to 30-34 F., dependent upon the size of the patient and apparent normal tightness of the canal. In the very young, proportionately smaller instruments are employed; in a girl of 5 years a final dilatation of 18 or 19 F. is adequate. In the aged, a urethral caliber of 28 F. usually suffices.

Silver nitrate is applied topically through an endoscope, or by catheter. I prefer the former method. While there are those, especially gynecologists, who employ the knee-elbow position for this treatment in women, we regularly administer topical endoscopic applications with the patient in the usual lithotomy position. When endoscopic visualization of the deep urethra is desired, following introduction of the urethroscopic tube and withdrawal of the obturator, the bladder is completely emptied of fluid, the tube then withdrawn somewhat, and the adjacent posterior urethra is dried with a long cotton applicator. However, the lesion should have been visualized by previous cysto-urethroscopy so that subsequent endoscopy is only occasionally required for progress check-up. By experience one becomes instrumentally oriented in the deep urethra without visualization, so that when applications are to be made to the entire urethra and anterior trigon, endoscopic light is unnecessary.

The method I have found most satisfactory is as follows: After passage of the endoscope to the bladder, the obturator is withdrawn sufficient to permit a slow escape of urine from the bladder. The tube then is slowly withdrawn until the leakage of urine ceases; indicating that the tip of the instrument is just outside the internal sphincter. The obturator is then fully re-introduced and the endoscope gently inserted 1 cm.; which brings it just within the vesical outlet. The obturator is then withdrawn and the bladder completely emptied. While maintaining the endoscope in this position, a long cotton applicator saturated with the silver nitrate solution is introduced 1 cm. beyond the inner opening of the tube, and by lateral, wide, sweeping motions of the instrument, the anterior trigon receives its application. Following this, the endoscope is slowly withdrawn with the applicator extending slightly beyond the tube orifice, and application to the vesical outlet and entire urethra is accomplished.

When the mucosa is hypersensitive, it is usually unwise to apply silver nitrate with the first dilatation. At the subsequent treatment we usually begin with 5% silver nitrate solution, which is later increased to 1, 2, 4, 6% and, as a rule, ultimately to 10%. There are such striking differences in urethral temper that only by observation in a given case can the proper maximum strength of silver nitrate be determined. When treatment has not been too severe, local reaction should last less than ½ hour.

When the catheter method of instillation is used, 1-2 dr. silver nitrate solution is injected into the bladder; the injection is continued while the catheter tip is being withdrawn through the urethra. After 30 seconds the bladder should be washed clean, preferably with normal saline which at once checks further action of the silver nitrate by the precipitation of silver chloride. When silver solutions are introduced directly into the bladder, the initial injection should not be stronger than 1:500 and the maximum strength used should not be over 1%. Although the catheter method is simpler, in my hands the best results have been obtained by endoscopic applications.

As a rule, there is striking symptomatic improvement after 2 or 3 treatments. Some patients are entirely relieved of symptoms with their second treatment, but because the submucosal and peri-urethral infiltrate is not absorbed with this limited therapy, further dilatations at lengthening intervals are advisable to insure greater permanency of relief. Even though no associated lesions exist in the upper urinary tract, urethrotrigonitis shows a marked tendency to recurrence, yet the asymptomatic

interval may be as long as 2 or more years. When there is no improvement in 3 treatments as outlined above, a urologic reëxamination will probably reveal an overlooked lesion elsewhere in the urinary tract.

Urethral Stricture

This lesion is a common sequel to chronic urethrotrigonitis; the peri-urethral inflammation having led to scar formation, with concentric contraction and urinary obstruction. With urethral stricture, there is always urethrotrigonitis. Because urethrotrigonitis is usually most marked in the posterior third of the urethra, urethral stricture is most common at this point. A striking exception is the congenital atresia or stricture of the urethral meatus which is far more common in women, as is urethral stricture elsewhere, than is generally recognized. Inflammatory stricture frequently follows gonorrheal infection but may also be caused by non-gonorrheal invasions. A large number of these lesions follow urethral trauma due to child birth, difficult coitus and masturbation.

Pathology: The histologic picture is that of urethral and peri-urethral inflammatory infiltration and sclerosis. When the inflammatory element predominates, that is, before scar formation is marked, the lesion is analogous to the soft infiltration stage of stricture in the male as described by Oberländer. With advanced sclerosis, strictures of filiform caliber are sometimes observed in women. Here, the upper urinary tract damage is identical with that which occurs with advanced urethral stricture or prostatic obstruction in the male. There is marked dilatation of the entire upper tract, with compression nephritis and, if the obstruction is not relieved, ultimate bilateral destruction of the kidneys. I have recently observed this in a woman 50 years of age.

Symptoms are those described under urethrotrigonitis, but with stricture the dysuria phase is apt to be more pronounced. There may be chronic partial or complete vesical retention. In advanced stricture disease, infection with marked pyuria is the rule. When renal damage is extreme, symptoms of uremia may occur.

Diagnosis is made by the passage of urethral sounds or bougies, which are grasped by the stricture; and by endoscopic visualization of the lesion. In an adult female, one should be able to pass a 24 F. sound without obstruction to its introduction and without grasping of the instrument on its withdrawal. The passage of olivary bougies serves to identify the site of stricture and indicate roughly its caliber. Endoscopically, stricture is identified by the sclerotic anemia and constriction of the diseased area. Usually, the overlying mucosa bleeds easily, and often superficial granulations are observed. Occasionally, the stricture is of filiform caliber; an observation which at once urges the importance of the lesion.

Treatment of stricture is persistent and prolonged dilatation. The fundamentals of urethral dilatation in the female have been described under the treatment of urethrotrigonitis. It is noteworthy, however, that the dilatation of stricture may progress slowly, and as the sounds of increasing size encounter greater obstruction to their passage, the quantitative dilatation at each treatment diminishes. Dilatation should not cause bleeding; usually this indicates laceration of the mucosa, which means more scar later. The first sound passed should be smaller than the minimum caliber of the urethra as established by the diagnostic investigation. Usually it is unwise to pass more than 3 sounds at one treatment, and the interval between treatments should seldom be less than a week. Dilatation is carried on until the normal maximum is reached (32 to 34 F.). As the urethral caliber increases, the interval between treatments is lengthened, so that eventually dilatation once in 6 or 12 months suffices to maintain a normal caliber.

When the scar is extremely dense and instrumental dilatation fails, internal urethrotomy should be performed. When the stricture is at the meatus, meatotomy is indicated and permits more rapid and successful dilatation. A stricture is cured only when it remains dilated.

Ureteral Stricture

Hunner was the first to call attention to the great clinical importance of this rather common condition which, though affecting both sexes equally, has received most attention

as it concerns women. Although the ureteral obstruction commonly causes renal pain and other upper tract symptoms directly explicable by urinary back pressure and infection, in 75% of cases the entire symptomatology is referred to the bladder outlet and is manifested only by vesical irritability. It is with the latter group that we are here concerned.

Etiology. The work of Hunner and others strongly suggests that ureter stricture as commonly observed is localized ureteral inflammatory sclerosis secondary to a focal infection elsewhere. This is probably the most frequent etiology. Only 1% of all individuals are born with ureteral stricture; in many others the stricture results from antecedent urinary tract infection or infectious processes adjacent to the ureter.

Pathology. There is an inflammatory infiltration with sclerosis, involving especially the submucous and muscular coats of the ureter. In 1/3 of those patients the urine is normal and sterile; in ½ the urinary findings are meager. Upper urinary tract dilatation occurs above the obstructive lesion. The vesical outlet irritative symptoms may be due to associated infection, although, when the urine is sterile, the lower tract symptoms are a reflex manifestation.

Symptoms. In ¾ of all ureter stricture patients the symptoms commonly lead to the diagnosis of chronic cystitis. The vesical disturbances are usually those described under urethrotrigonitis. When ureteral or renal pain is added, chronic pyelitis is usually incorporated in the diagnosis. In the discussion here we are concerned with only those cases of ureter stricture in which upper tract symptoms are absent and vesical outlet manifestations simulate those due to bladder inflammation.

Diagnosis is made by ureter instrumentation plus ureterography. A wax-bulb catheter is passed up the ureter; and any obstruction elicited in its upward passage, or localized catch or "hang" on withdrawal of the bougie, is suggestive of ureter stricture, although it has been amply proved that often the "hang" is due to normal ureteral narrowings, normal vascular crossings of the ureter or localized ureterospasm. In the ureterogram there is localized narrowing at the point of "hang" and the ureter above this point is dilated. Unless dilatation is found above the suspected point, many urologists—including the writer—will not make a diagnosis of stricture. Keyes, for example, considers most of these lesions as localized ureterospasms.

Treatment. Focal infections should be eliminated and urinary infection controlled as far as possible by antiseptics. The principal treatment consists of periodic dilatation of the stricture by passage of ureteral bougies of progressively increasing diameters. Often, no larger than a No. 6 or 7 F. catheter can be passed at first, but with patience and repeated instrumentations at fortnightly or monthly intervals, the ureteral obstruction may ultimately be dilated to 10, 12, or 14 F. In many patients the symptoms and urinary obstruction are admirably controlled by the maintenance of a No. 10 F. minimum caliber. It is likely that Hunner has dilated strictures to a greater caliber than others, for he states that many patients are unrelieved or remain uncured until ureteral bougies as large as 18 F. have been passed. The writer does not pass bougies larger than 13 F.; there is always added risk in going above this caliber and, except in rare instances, the desired results can be obtained within this limit of dilatation. Many of these patients with ureter stricture have an associated chronic urethrotrigonitis, and unquestionably much of the improvement attributed to ureter therapy is due to urethral dilatation by passage of the cystoscope.

When the treatment of ureter stricture as outlined above is unsatisfactory, a careful urologic re-survey is always indicated; a hitherto unrecognized lesion will probably be found.

Submucous Ulcer

Submucous ulcer is a chronic inflammation of all the coats of the bladder wall, and is characterized clinically by an unusual severity and persistence of symptoms despite normal or nearly normal urinary findings. The lesion was first described by Hunner and was soon designated as—"Hunner ulcer"—although some observers have used the terms elusive ulcer, paracystitis, interstitial cystitis, and circumscribed pan-mural ulcerative cystitis. Be-

cause of the relatively insignificant cystoscopic picture of the lesion, the diagnosis is commonly missed.

Etiology. Clinical and experimental evidence indicates that submucous ulcer is due to bacterial metastasis from a local infection. Meisser and Bumpus obtained streptococci from dental apical abscesses in 15 patients with submucous ulcer; and of 19 animals injected with organisms obtained from these dental foci 13 developed submucous ulcer of the bladder. Hinman reproduced the lesion in the rabbit bladder by inoculation of organisms obtained from resected specimens of submucous ulcer in the human.

Pathology. Cystoscopically, submucous ulcers appear as small superficial lesions surrounded by an intensely red zone of hyperemia which is commonly marked by edema. The lesions may be single or multiple and are usually observed as mucosal cracks 2 to 6 or 8 mm. Elsewhere the bladder appears normal. Histologically, the bladder wall shows chronic inflammation of all its coats, and at the ulcer site there is loss of epithelium with, often, a base of granulation tissue. There is marked vascular engorgement peripheral to the ulcer margins and, commonly, edema. The deeper tissues show an increase in connective tissue as well as a marked lymphocytic infiltration; scattered polymorphonuclears are frequently observed. The healed ulcer shows sclerosis. Generalized fibrous contraction of the bladder wall (due chiefly to sclerosis of the submucous layer), plus reflex spastic detrusor contraction, result in a considerable diminution of vesical capacity. This accounts, in a large measure, for the unusual frequency, urgency and detrusor pain so regularly observed. In résumé, the striking difference between the pathologic picture of submucous ulcer and the more usual chronic cystitis is the marked involvement of the deep bladder coats in the former, with relatively slight lesions in the mucosa.

The symptoms of submucous ulcer are those described under urethrocystitis, but far more severe and likely to be overshadowed by excruciating vesical pain, usually stabbing in character, localized to the bladder itself or referred into the urethra; and often increased by constipation and by bowel movements. Frequency may be as marked as every 20 minutes day and night, and extreme urgency causes many of these patients to wet their clothing. Hematuria is rarely noted by the patient.

Diagnosis. A history of persistent extreme frequency, urgency and vesical pain is suggestive of submucous ulcer, especially when there have been numerous fruitless attempts at instrumental or surgical treatment. The urine is usually macroscopically normal and sterile, though microscopically scattered pus and red blood cells may be found. This disproportion between the severity of the symptoms and the cystoscopic and urinary findings is a striking characteristic of the disease. The cystoscopic appearance has been described under the head of "pathology". The ulcers are most often found on the bladder dome or on the anterior wall, and by slight over-distention, a cracking and bleeding of the ulcer at once establishes the diagnosis. Sometimes the introduction of but 40 c.c. fluid will cause mucosal cracking. The ulcer is exquisitely sensitive to touch. During cystoscopic examination these lesions may change appearance somewhat, and in a follow-up series of examinations, the bladder picture changes considerably with the healing of ulcers in one portion and the appearance of new lesions elsewhere.

Treatment. Focal infections should be eliminated, particularly dental, pharyngeal and sinus lesions. In the early years of its recognition, submucous ulcer was treated by radical excision of the involved bladder wall, but recurrences were the rule and open surgical treatment has been largely supplanted by cystoscopic fulguration of the ulcer areas.

In most cases of moderate severity we have found the use of silver nitrate solution in progressively increasing concentrations a satisfactory method of treatment. The bladder is emptied by catheterization but, before withdrawing the tube, 1 oz. of 10% novocaine hydrochloride is instilled and allowed to remain for 15 minutes to obtain anesthesia of

the mucosa. The novocaine is then withdrawn and the bladder is filled with silver nitrate solution to the point of slight distention pain. After 30 seconds, or sooner if the patient demands, the silver solution is withdrawn and the bladder irrigated with normal saline until the return no longer indicates precipitation of silver chloride. A small amount of novocaine is then re-introduced into the bladder. These treatments are repeated at intervals of 7 to 14 days; as improvement occurs, the intervals are correspondingly lengthened. As a rule, I begin with a 1:600 silver nitrate solution. At the following treatment I use a 1:500 solution and, if the reaction is not severe, solutions of 1:400, 1:300, 1:250 and 1:200 are progressively used at subsequent visits.

Most patients respond admirably to this treatment which, when ineffective, may be replaced by fulguration of the individual lesions. Submucous ulcer is a chronic disease showing a marked tendency to recurrence; therapeutically we should speak of *control* of the lesion or the symptoms *rather than cure*. However, there is probably no group of patients in which the alleviation of symptoms prompts greater gratitude. Many of these patients feel they have had a satisfactory night if they must urinate but 3 or 4 times.

Summary

Attention has been directed to 4 common urinary tract lesions in women (urethrocystitis, urethral stricture, ureter stricture and submucous ulcer) which are clinically manifested by urinary frequency, urgency, dysuria, sometimes hematuria and extreme pain. In all there is a striking discrepancy between severity of symptoms and the urinary findings. All these lesions are characterized by a tendency to recurrence. Diagnosis cannot be accurately made without careful urologic examination. It is notable that 2 or more of these lesions may coëxist; it is not unusual to discover ureteral stricture, urethral stricture and urethrotrigonitis in the same patient. Treatment of these lesions is instrumental rather than medical or operative, and fortunately may be accomplished without hospitalization.

TRANSPLANTATION OF URETERS IN EXTENSIVE VESICOVAGINAL FISTULA WITH DESTRUCTION OF URETHRA AND VESICAL SPHINCTER

Earl J. Halligan, M.D.,

Attending Surgeon, St. Francis Hospital, and Consulting Surgeon, Margaret Hague Maternity Hospital, Jersey City, N. J.; Consulting Surgeon, Holy Name Hospital, Teaneck, N. J.,

and

Harold J. Halligan, M.D.,

Assistant Surgeon, St. Francis Hospital, and Assistant Visiting Obstetrician, Margaret Hague Maternity Hospital, Jersey City, N. J.

In the treatment of vesicovaginal fistula, one is confronted by the fact that, in order to relieve the patient of physical distress, mental anguish and social isolation, repair or reconstruction of the urinary reservoir, with sphincteric control, must be accomplished. In the majority of cases this can be accomplished with comparative ease, but a certain number tax the ingenuity and skill of the cleverest operator. These are particularly the fistulas where (a) there has been extensive loss of tissue; (b) the tissues are so firmly fixed as to prevent mobilization; (c) the fistulas are inaccessible. Treatment of the last named has been simplified to some extent by following the principles set down by George Gray Ward, namely: sufficient exposure (lateral vaginoperineal incisions, Schuchardt paravaginal incision), free mobilization of bladder, displacement of bladder downward, and correct suturing of the layers in different planes.

Now, we come to those cases, fortunately not many, where we are confronted by extensive loss of tissue, particularly destruction of the base of the bladder, including the sphincter, and part or all of the urethra. Many suggestions have been made as to transplantation of tissue in order to repair these defects. Transplantation of tissue, either free or by pedicle, demands an aseptic field, a condition never present in a fistulous vagina. Strips from fascia and vagina, labia majora, vaginal mucous membrane, or vesico-uterine peritoneum, have been used to correct the bladder

defect; while tunneling and flap operations, or transplantation of fallopian tubes and appendix, have been used for the urethra. The results obtained in some of these cases have been brilliant, but the number is notoriously few, most being doomed to failure.

R. T. Frank has suggested utilizing the corpus uteri, bringing it through the cut cul de sac (as in interposition operation), as means of filling an extensive defect, even where there is loss of sphincteric control; the idea being, that the fundus will act as a ball for pressure beneath the neck of the bladder. The application is limited, because many of these cases are the result of obstetric trauma and have associated pelvic pathology, fixing the uterus with adhesions and difficult to mobilize. Even where the urethra is reconstructed after a series of operations, the patient is dissatisfied, since sphincter control can never be supplied once it is completely destroyed. With the reconstructed urethra, the bladder fills to a certain level, then overflows, particularly if the patient is much on her feet.

What shall we do, then, in the case of extreme destruction of the vesicovaginal septum and urethra? The following courses are open: (1) Leave the patient to pursue her unhappy course as she is? Decidedly not. (2) Colpocleisis: Very unsatisfactory. Does not give a urinary reservoir with sphincter control. Sooner or later urine becomes infected, calculi often form, ascending urinary infection is common, and often vagina has to be reopened to relieve suffering. (3) Colpocleisis with rectovaginal fistula: The advantages of this are: a urinary reservoir with sphincteric control; preservation of the ureteral orifice; sphincter and an extraperitoneal operation. The disadvantages are: calculi are apt to form in various diverticulum-like divisions; prohibits copulation; necessitates passing menstrual blood by rectum; subjects urinary and genital tracts to contamination from contents of cloaca; and last, but not least, the psychic effect of vaginal obliteration forms a risk. (4) Ureteral transplantation: The advantages are: a urinary reservoir with sphincteric control is established; physiologically it is transmutation from mammalian to avian type of eliminative system; is an organ in which absorption coefficient is low; a more normal genital tract; copulation is permitted; normal menstrual discharge of blood; psychic effect good; pregnancy may follow (in a case of Lower's 7 years ago, a normal child was delivered); pregnancy is not dangerous, if there is not much previous infection present.

Infection is the greatest danger, even with a most careful technic. It may occur from the operation itself or from intestinal wound.

The danger of ascending infection has been greatly diminished since the monumental work of Coffey, in showing that a properly constructed valve at the end of the transplanted ureter amply protects against intra-intestinal pressure and ascending infection.

Transplanting ureters is an operation of the first magnitude. There is no shock to the operation, but it demands an exacting technic. In this operation, both peritoneal cavity and retroperitoneal space are opened, and consequently either may be infected. Peritonitis may occur, or postoperative ileus, or the retroperitoneal tissue may become involved with a secondary chronic sepsis. Occasionally, the ureter sloughs from deficient blood supply. In operating, certain things are to be remembered; the ureters may be small and hard and fixed, or only one ureter may be present; if such is the case, it is larger than normal (no need of doing second operation). Obstructions may be present in one ureter. This may be taken care of by bilateral transplantation with catheter. Hemorrhage may occur from the rectum, so all bleeding points (even the tiniest) must be carefully tied. Retention of urine in the rectum may take place, postoperatively, so the rectum should be drained with tube, a few hours postoperatively. Postoperatively, enema should not be given for a few days. One death has been reported, due to rupture of the rectum, at site of transplantation. Of course this operation removes ureters from the field for further study, but with the advent of uroselecton, this disadvantage has been removed.

Pelvic infection may be present. In this event, transplantation should not be done until the infection has subsided. The presence of rectovaginal fistula, or a complete laceration

of the perineum, would defeat the purpose of the operation—namely, a urinary reservoir with sphincteric control—so the former conditions should be repaired first.

Case report: Anna B. was admitted to hospital April 14, 1928, with history of having been delivered 9 days previously. She had been in labor about 70 hours, then delivered instrumentally. Patient was a small white woman, acutely ill and very apprehensive. Physical examination showed: vulva markedly swollen, reddened and inflamed; a laceration, about 4 in. long, extended from vagina through right labia majora (upper part), upward over mons veneris; a profuse, then purulent, discharge, with urinous odor; inner surface of thighs (down to middle), perineum and buttock excoriated; vulva so swollen and tender it was impossible to introduce even one finger without exquisite pain. Wet dressing was applied to vulva and thighs, and patient put on Bradford frame and elevated, so discharge of urine would flow directly down into pan beneath the frame.

On April 24, 1928, pelvic examination, under nitrous oxide, disclosed urethra absent; laceration extending from former site of urethra up over pubes; the whole vesicovaginal septum, except one strand running from uterus to pubes, had sloughed away: most of cervix had disappeared; second-degree perineal tear extended up into sulci; uterus somewhat enlarged and fairly movable. Wet dressings were applied, zinc oxide paste used on excoriated skin, and vagina irrigated daily, with low pressure douche.

On June 26, the customary 6 weeks having elapsed, and this being the usual optimum time for repair of vesicovaginal fistula, the patient was again examined. As she was intractable and apprehensive, she was again given gas anesthesia. Examination showed tissues had cleaned up considerably, but again corroborated previous findings, with the additional fact that all the vaginal portion of the cervix had sloughed away.

After consultation, it was decided that the loss of tissues was too great to repair by plastic measures, and some other method must be used. General condition of the patient, at this time, was not good enough for any operative procedure. On June 30, she had a chill and rise of temperature (104°), with severe pain in region of both kidneys; palpation revealed marked tenderness in costovertebral angles. Diagnosis: pyelitis. This of course precluded any operative procedure. Under the exhibition of the usual urinary antiseptics—caprokol, urotropine, etc.—patient ran a septic temperature until July 26. From then on, temperature remained flat, and on August 13, a right ureteral transplantation was done.

Under gas and oxygen, an oblique incision was made, about 4 in. long, 1 in. above and parallel with Poupart's ligament; right ureter was located and dissected free; upper rectum was clamped off. Distal end of ureter was ligated and ureter cut. Retroperitoneal space was closed off. An incision, 1½ in. long, was made through wall of rectum, down to mucosa; a fine (double 00 chromic) suture was passed through lower end of ureter and tied, the free end (about 1½ in. long) passed up the ureter and, to maintain its lumen (on account of edema), a stab wound was made at lower end of mucosa, the ligature on needle, passing through stab wound, from within out, through all coats of intestines, ½ in. below stab wound; ureter was drawn through mucosal opening and suture tied; and seromuscular coats sewn, every other stitch taking a bite in the outer ureteral coat. Peritoneal coat of the rectum, at upper angle of incision, was trimmed off so as not to constrict the ureter at this point. A second layer of fine chromic sutures still further reinforced and covered the first line of sutures. Abdomen was closed and drain inserted down to peritoneum.

Recovery from operation was fairly good, with slight postoperative rise (101°) of temperature, which came down to normal after 48 hours. Drain removed. Patient did well until August 18, when she had a sudden rise of temperature to 105°, with pain and tenderness in both loins. No signs of abdominal involvement present. Diagnosis: recurrence of the pyeltis. Patient again treated with fluids, urinary antiseptics, etc. On August 21, sutures removed. Wound was clean and dry. Patient ran a septic temperature, varying from 100° to 103°, until August 25. Temperature stayed down for one week; then patient ran

a temperature for 10 days more. Temperature finally flattened down and patient felt fairly well, with no evidence of any infection. Waited until October 15; then, temperature having been flat for nearly a month and patient's condition being fairly good, we decided to transplant the other ureter. This was done on October 16, under spinal anesthesia, following the same technic as on the opposite side. This time, postoperative reaction was not as severe, temperature rose to 103°, but dropped 2 days later to normal. On October 24, sutures were removed; wound clean and dry. October 27, patient up and around. Had urinary control for 2-3 hours during the daytime, and 4 hours at night.

On November 8, patient was discharged, with instructions to report back within 2 weeks. Patient was not seen for about 8 months. Had complete urinary control for 4-6 hours during the day, and often about 8 hours at night; but now complained about vague discomfort in lower abdomen, associated with nausea. This had passed off, and on day of examination, she was all right. One month later, patient was seen with the same type of attack, but more severe. Had severe pains in lower abdomen, nausea and vomiting. History revealed she had not menstruated since delivery. Examination revealed uterus about size of an orange, markedly tender, no cervix present. Diagnosis: hematometra. After a few days this subsided, but recurred 4 weeks later.

An attempt was made to establish an artificial opening in the uterus, but this was crowned with failure. Therefore, in May 1929, a hysterectomy, under spinal anesthesia, was done. Ureters, palpated at that time, were slightly enlarged and thickened but not markedly so. General condition excellent; blood count, normal; blood chemistry, normal. Patient was discharged after 2 weeks.

May 1931: Patient still in good condition, feels fine, no complications. Tried to induce her to have x-rays taken, with uroselecton, in order to visualize the G. U. tract, but she refused, saying she felt all right.

Comments: The above case report presents: (1) The opportunity, one year later, to examine the anastomosis, ureters and kidneys. There was no dilatation of the ureters, and kidneys were normal in size and shape; no hydronephrosis. (2) Having had a rather severe ascending urinary infection, which lighted up after first operation, there was little reaction after the second operation, and patient has been free of any symptoms suggesting urinary infection. Improvement in the infection has been noted, after transplantation, both clinically and by x-rays with uroselecton. Hepler reports 3 cases with marked improvement. (3) No drainage of the peritoneal cavity in this case, but drains in abdominal wall. Furniss, in his 3 cases, has not drained any.

Analysis of Cases: Forty-two cases collected from literature, with 3 deaths reported. One death, postoperative, due to rupture of bowel, at site of anastomosis, following administration of a large enema: no autopsy. One death reported, postoperatively, due to alkalosis. Autopsy disclosed no reason for the death, and the uretero-intestinal anastomosis was perfect. One death occurred 2 years later, due to recurrence of the carcinoma of the cervix, and not due to the anastomosis. One case reported, unsatisfactory.

Although the number of cases reported is small, and the time recent (most of them since 1926), the results on the whole are very satisfactory. All patients have been relieved of the distressing condition for which this particular operation was applied, and there seem to have been no complications or bad results in the cases reviewed in the literature.

Waltman Walters reports results in 76 cases of ureteral transplantation and cystectomy for exstrophy of the bladder. These are analagous to those with extensive vesicovaginal destruction, following childbirth, with the added advantage in the latter that they are not followed by cystectomy and are not done in the very young (42 under 14). In his report, 3 patients died subsequent to operation, and 3 had unsatisfactory results.

In 50% of these cases, there was no evidence of renal infection; in 21%, infection was so mild as to have little effect on the patient. These results are encouraging, but one must not become too enthusiastic. We still feel that vesicovaginal fistula, in the majority of cases, should be treated by plastic operation, and ureteral transplantation done only

in those where so much tissue is destroyed or fixed (due to obstetric trauma, radium burns, repeated operations) that any other course is futile.

Summary: (1) Unless the patient has a sphincter controlled urinary reservoir, the physical discomfort, mental suffering and social isolation, due to continuous discharge of urine, offer a hopeless outlook.

(2) In extensive destruction of the base of the bladder, vesical sphincter and urethra, repair or reconstruction of the bladder is not successful, except in isolated cases.

(3) Transplantation of the ureters into the large intestine, whether done singly or simultaneously (tube technic), offers the best hope of restoring the individual as near to normal as possible.

(4) However, this operation must not be taken as routine, but after a careful survey of the case, and finally deciding that repair of the fistula is impossible.

(5) We must not be unmindful of the danger of infection, usually from the intestinal wound, with resulting peritonitis; sometimes the ureter sloughs outside the intestine, from deficient blood supply; slight infection gives postoperative ileus or infection in retroperitoneal space, due to colon bacilli, and gives chronic sepsis. The mortality from above causes is an irreducible minimum. This may possibly be eliminated with Coffey's new transfixion suture technic.

(6) Colpocleisis has no place in modern surgery.

(7) Colpocleisis with rectovaginal fistula may be used occasionally in the old, the debilitated, and those beyond the menopause.

DEMENTIA PARALYTICA: DIAGNOSTIC ERRORS AND THEIR PREVENTION

Karl Rothschild, M.D., F.A.C.P.,
Director, Department of Neuropsychiatry,
St. Peter's General Hospital,
New Brunswick, N. J.

The great advances made in diagnosis of dementia paralytica by serologic and cytologic examination of the spinal fluid have not been entirely parallelled by early clinical discovery of this disease. Before the discovery of the Wassermann reaction, the majority of cases were classified as paranoiac dementia, and depression or involutional melancholia, with the possible exception of the "classical" expansive form, which formed a disease unit *per se*. Thus, in spite of Erb's teaching that dementia paralytica was of syphilitic origin, the greater number of cases were not properly diagnosed before Wassermann's time. The dictum that dementia paralytica should never be diagnosed in the absence of physical signs of pathology, has unduly retarded many diagnoses, especially before spinal punctures became a routine procedure. It is evident that presence of mental deterioration or depression, without demonstrable pupillary or reflex changes, has prevented the performance of a spinal puncture and thus the correct diagnosis. It is just as evident that the diagnosis is frequently overlooked when the earliest symptom is an apoplectic attack, when the affected person is very young, and when vascular syphilis is present.

In view of these considerations, this paper will describe and analyze 4 cases which we recently had the opportunity to observe. In order not to complicate the presentation, discussion shall be limited to the *diagnostic* features only.

Case 1. F. A., white male, aged 38, laborer, was seen in consultation on December 1, 1932. He had been in the Italian army 20 years ago and had contracted gonorrhea, for which he had been treated adequately. No antisyphilitic treatment had been administered. He is married and has 3 healthy children. His wife is healthy and has had no miscarriages.

About 6 months ago, the patient consulted his family physician with complaints of nervousness, restlessness and occasional insomnia. At times he complained of fears of indefinite character. A thorough examination at that time revealed no abnormalities. A Wassermann test was performed as a routine procedure, and showed a 4+ reaction. Thereupon he was treated with neo-arsphenamine, with no improvement. In fact, the insomnia grew worse and delusions of fear increased.

In consultation, the following findings were

recorded: Heart normal in outline and action; no murmurs heard. Lungs showed vesicular breath sounds over all lobes. Abdomen soft. Liver and spleen not enlarged. Pupils normal, round, equal in size to one another, and reacted promptly to light and convergence. Eyegrounds showed a very mild peripapillitis. Biceps and triceps reflexes normal. Patellar reflexes exaggerated. Babinski's sign negative, clonus absent. Abdominal reflexes exaggerated. Constant tremor of hands and tongue. Cerebral nerves appeared unimpaired. No ataxia. Finger-finger and finger-nose tests performed well. Romberg test showed no falling and no swaying. Speech indistinct, "washed out". Test sentences repeated with transposition and repetition of syllables.

A diagnosis of *dementia paralytica* was made and a spinal puncture performed. The fluid showed normal pressure 4 cells per c. mm. (3 lymphocytes and 1 polynuclear), marked increase in globulin, 47 mg.% sugar, Wassermann reaction 4+, colloidal gold curve 5555432100; which findings made diagnosis of dementia paralytica definite. Patient's wife's blood Wassermann was also 4+.

It is to be noted that the only clinical symptoms suggestive of dementia paralytica, besides the positive Wassermann, which had been done as a routine examination, were tremor of the hands and tongue and peculiarities of speech. The exaggerated patellar reflexes cannot be considered pathognomonic in view of the equally strong exaggeration of the abdominal reflexes. In fact, the patient was considered a neurasthenic until the Wassermann reaction showed syphilitic infection. Ordinarily, such a patient might travel for years under the diagnosis of neurasthenia. The absence of pupillary changes is especially significant, as the presence of disturbances in this field is usually considered to be one of the first signs.

Case 2. Mrs. M. L., white, aged 22, housewife, was referred to us by a general surgeon whom she had consulted for paralysis of the legs which occurred after the birth of her third child, 2 years ago. Past history was entirely negative. She has been married 6 years and has had 3 children, all of whom are living and well. No abortions. Third child was born February 11, 1931. About 3 weeks following this delivery, she suddenly developed tremor of hands, speech difficulties, and stiffness and weakness of her legs, more so on the left side. The condition was apparently considered as cerebral embolism by the family physician. Since this time, her condition has remained stationary, with the exception of several short-lived remissions. At present, her legs are a little stiffer than at the onset.

Physical examination showed a well-nourished female with a sallow skin. Heart was normal in size and action. Pulse rate, 72. Blood pressure findings, 120/74. Lungs showed no pathology. Abdominal organs normal in size. Pupils unequal in size; right pupil oval in outline; neither reacted to light or convergence (fixed pupils). Eyeground examination revealed presence of pallor, more pronounced in the temporal halves. Patellar and Achilles tendon-reflexes pathologically exaggerated, with increase of their reflexogenic zone. Babinski's sign positive bilaterally. Slight ankle clonus on left side. Abdominal reflexes absent. A rather coarse tremor in both hands and the tongue.

A diagnosis of dementia paralytica, congenital form, was made, and a spinal puncture performed. The spinal fluid examination revealed a 4+ Wassermann reaction, 67 mg.% of sugar, a marked increase of globulin, a cell count of 4 (3 lymphocytes and 1 polynuclear) and a colloidal gold curve 5555542100. The blood showed a 4+ Wassermann reaction. The Wassermann reaction of the husband proved to be negative.

In this case, also, the diagnosis of dementia paralytica was fully substantiated by serologic methods. The important points which led to misinterpretation were the age of the patient, and the onset with apoplectiform features following childbirth. It is very probable that we are dealing with a congenital case; otherwise the onset at the age of 20 years would be extremely improbable. We have no means of examining the parents or sibs. What made the diagnosis more difficult yet was the apoplectic onset with, at first, monolateral involvement, suggesting cerebral embolism. Examination of the eyes, reflexes and especially the

typical speech disturbance should have led to a correct interpretation. It should be emphasized that a great many patients show their first observable symptoms in the form of apoplectic seizures.

Case 3. H. P. K., a male white, aged 51, formerly an accountant, was examined on July 10, 1931, because of his mental abnormalities: emotional instability, silly behavior, and bad table manners. He gave a history of syphilis and had received antisyphilitic treatment until shortly before this consultation. A report furnished by the laboratory where Wassermann tests had been performed on him at intervals showed that the reaction had gradually been reduced from 4+ to 1+ and that the latest test had been negative.

Physical examination revealed an emaciated individual. Heart, lungs, pulse, blood pressure and abdominal organs normal. Pupils fixed; did not react to light or convergence. Patellar reflexes exaggerated. Tremor of hands. Romberg's test positive.

A diagnosis of taboparesis was made and the patient admitted to St. Peter's Hospital. Spinal fluid tests showed 8 cells, an increased amount of globulin, a negative Wassermann reaction, and a colloidal gold curve which was atypical but resembled rather closely that found in tabes. During the stay in the hospital and before any treatment had been started, patient developed symptoms which, by themselves alone, would have permitted proper diagnosis. He became filthy, drank his own urine, and painted the walls of his room with his feces.

Although we are here concerned mainly with diagnostic considerations, it should be mentioned that, under treatment with tryparsamide and bismuth, the patient made a good recovery, and today leads a relatively normal life. He has had no relapse in 18 months.

The diagnostic difficulties in this case are represented by the negative spinal Wassermann reaction and the atypical gold chloride reaction. On admission to the hospital, the intern made a preliminary diagnosis of neurasthenia. The developments in patient's behavior, and prompt response to proper and adequate treatment, make the diagnosis of taboparesis definite. It is especially worth noting that the Wassermann of the spinal fluid had become negative under treatment with arsphenamines.

Case 4. J. T., white male, aged 35, laborer, was admitted to St. Peter's Hospital on September 9, 1929, because of pains in his chest and irrational talk. The history revealed that for about a year patient had complained of dyspnea and swelling of the abdomen. One week prior to admission, he had begun to suffer from repeated attacks of vomiting. For the past 4 days, he had been talking irrationally, in a filthy manner. He has been married 7 years. His wife has given birth to one premature child and another child who died 2 days after birth.

Physical examination disclosed a dilatation of the heart, with aortic insufficiency and stenosis, which the attending internist definitely classified as of syphilitic origin. Presence of pulmonary edema was noted. Abdomen slightly swollen, liver enlarged. Pupils unequal in size; did not react to light and only very faintly to convergence. Tremor of the hands. Patellar reflexes markedly exaggerated, and ankle clonus present. Blood Wassermann reaction 4+. Spinal fluid examination showed increase in globulin, a cell count of 32 and Wassermann reaction 4+. Colloidal gold curve was not examined.

Diagnosis was dementia paralytica in combination with vascular syphilis. The patient was removed to an insane asylum where the diagnosis was confirmed.

This case is cited because it was, and frequently still is, believed that vascular and cerebrospinal syphilis do not occur in the same patient. A special neurotropic form of spirochete was held responsible for the cerebral invasion. We will not discuss this phase of the problem. For our purpose it is sufficient to show that the presence of vascular syphilis does not *eo ipso* exclude dementia paralytica.

This discussion being concerned with the *diagnosis* of dementia paralytica only, no particular space is devoted to questions of transmission and therapy. As a general rule, however, it may be stated that early cases are best treated by inoculation with malaria, which can be done in most state hospitals for the insane. Frequently a non-deteriorated patient

will consent to enter such a hospital voluntarily, as happened in Case 1. It should, however, be emphasized that following the malaria inoculation, a course of tryparsamide injections is advisable. The malaria treatment puts a great strain on the general physique and is not without danger. In advanced and emaciated cases, it is therefore preferable to start with a course of tryparsamide, during which the patient generally gains weight. Naturally, proper attention to the eyegrounds is necessary, and the treatment should not be given by the general practitioner. How well some patients respond to this treatment alone, is illustrated in Case 3.

Several important points are evidenced in the study of our cases. In the first place, every patient who has had syphilis should have a spinal puncture performed not only immediately following the regular antisyphilitic treatment but also *regularly* every few years thereafter. It should be the duty of the attending physician to emphasize the importance of this measure and supervise its enforcement. This test, however, is not sufficient. A colloidal gold curve is of the greatest importance, especially in *treated* cases, as any deviation in this test will arouse the necessary suspicion and cause proper treatment to be instituted at a very early period. In spite of recent comment to the contrary, it still appears necessary to perform a Wassermann test of the blood, and also possibly a spinal fluid examination, on *every* patient with mental abnormality or physical disturbance in any way suggestive of cerebrospinal syphilis.

Lastly, it should be mentioned that the usual antisyphilitic treatment is absolutely insufficient—one might say worthless—in treatment of dementia paralytica (and tabes), and its institution only leads to unnecessary delay or, as Case 3 illustrates, to the greatest difficulties in finally arriving at the correct diagnosis.

Summary

(1) The pitfalls in diagnosis of dementia paralytica are illustrated by presentation of 4 cases: (a) A patient with normal pupils and reflexes; only changes in speech and character. (b) Onset at the age of 20 following childbirth, with apoplectiform picture (congenital case). (c) Negative Wassermann reaction of blood and spinal fluid following treatment with arsphenamine. (d) Co-existence of vascular syphilis with dementia paralytica.

(2) Treatment of dementia paralytica with the usual antisyphilitic drugs is useless. The choice between malaria inoculations and tryparsamide injections depends on the physical condition of the patient.

(3) Following antisyphilitic treatment, spinal punctures should be repeated every few years in every case. It is important to perform not only a Wassermann test but also a globulin estimation and a colloidal gold or mastic curve.

(4) A blood Wassermann test should be performed on every patient with mental disturbances. In those who have already been treated for syphilis, a spinal fluid examination, including Wassermann and colloidal gold tests, is also imperative.

MASS ACTION AND VIRULENCE IN BACTERIA

C. M. B. Gilman, M.D.,

Institute of Pathology, Paterson General Hospital, and Laboratory for Clinical Research, Arlington,

Arlington, N. J.

The first time that this condition was called to our attention was in the Spring of 1924, when Dr. Ewing had a compensation case referred to him for opinion. The patient, a man, had fallen from a ladder and fractured his right ankle. Subsequently it drained, although at the time of the trauma it had not been a compound fracture. Still later it became infected, and drained purulent material. Dr. Ewing received sections. The man's chest was x-rayed and a quiescent lesion of tuberculosis was discovered. The characteristic lesion of the ankle was a generalized osteomyelitis with practically a pure culture of staphylococcus albus, and yet, after careful examination of slides over a 3-day period, only 1 tubercle was found. The assumption was that following trauma, or preceding it, the joint had

been or had become tubercular and ultimately became invaded by staphylococci. This led to an investigation through the following years.

Another patient, Mr. E., in March 1931 had epidermophyton fungus of the hands. He worked as a photographer with his hands constantly in chemical solutions. When we first saw him his hands had the typical boiled-flesh appearance, with serous weeping. Culture presented the spores and typical growth of the condition. Alpine light was tried and various antiseptics were used, but the hands continued to crack. The patient became discouraged and disappeared. Two weeks later he re-appeared with a pustular condition of both hands. Culture from several pustules presented the yellow staphylococcus in each and no epidermophyton fungus. These superficial abscesses were opened and vaccine therapy instituted and the condition cleared up, with no recurrence. It would appear that the staphylococcus had driven out the fungus, just as, in the previous case, the staphylococcus had replaced the tubercle bacillus.

We had a similar case (Mr. K.) of epidermophyton of the feet.

Mrs. A. sustained a brush wound on the anterior aspect of her left leg in May 1932. Following this she developed erysipelas, running a temperature often as high as 105°. This was confirmed by the finding of streptococci on bacteriologic examination. A sinus developed on the anterior aspect of the lateral compartment of the leg, at the junction of the middle and lower third. This drained—at first serous, later purulent. Cultures at this time presented staphylococcus albus in large numbers. Considerable dissection of the anterolateral compartment resulted, but coincidently the condition of the patient improved, temperature fell, and from then on the case was purely one of local infection with healing. There was a period of 36 hours of transitory bacteremia of staphylococcus aureus.

Recently I received a direct communication from Dr. F. C. Hodges, Huntington, West Virginia, following a discussion of this subject with him: "Epidermophyton vesicular, both hands improved by staphylococcus aureus vaccine. All other remedies failed. Patient had multiple abscesses forearm."

Those of us who are on the laboratory side of medicine constantly see conditions wherein colon overgrows all other organisms. Staphylococcus aureus or albus overgrows, inhibits and even starves out competitors. In diphtheria, special ingredients are utilized to enhance growth of Löffler's bacilli; otherwise saprophytes will overgrow. In the intestines, by means of special media we are able to alter the flora, just as in the chemical laboratory by catalyzers, enzymes, ferments, etc., we are able to alter chemical equilibriums. At the present time we are conducting further experiments along this line, with the end in view that possibly saprophytes may be used to combat pathogens.

Recently we removed a tumor from the breast of a dog. There were many shotty masses in the deep fascia. Biopsy of these masses showed the malignant nature of this tumor. In subsequent days, this whole area became infected with staphylococcus aureus, broke down and discharged purulent material freely. Within one week the region became clean, granulations appeared and the wound healed. There has been no recurrence. The only medication was Dakin's fluid, used to flush out the culture just as one uses saline to flush out a wound in maggot treatment of osteomyelitis.

In inorganic chemistry we have a definite standing of the metals, known as the electromotive series. It means, for example, that iron stands above copper, and therefore, if we have copper in an electrolytic solution and iron is thrown in, the iron will go into solution and copper will precipitate out. This method is used in refining copper and in the electroplating industries. We are trying to find whether bacteria may fall into a similar series, biologically.

BILIARY TRACT INFECTION

F. Grendon Reed, M.D.,
Morristown, N. J.

Biliary tract infection is a subject so broad that volumes could be—in fact, are—written on single phases of it. This paper is to be confined to inflammatory changes as a result of low-grade infection, about and in the small vessels and bile radicals. It is not to be confused with liver abscess, so-called acute yellow atrophy from whatever cause, or the cirrhoses —Hanot's, Laennec's, obstructing biliary, syphilitic or tuberculous.

If we are to understand the pathologic changes which occur even to a limited extent, it is necessary for most of us to refresh our memories regarding hepatic anatomy and physiology. That the biliary tract should be considered an integral part of the digestive apparatus is apparent when we recall that in the embryo the liver is formed from the primitive foregut, which ends at the ampulla of Vater. It probably is the earliest off-shoot of the entire gut tuber. The liver is the largest gland in the body, constituting in the adult over 1/40 and in the fetus a little more than 1/20 of the body weight. It occupies nearly all of the right hypochondrium, most of the epigastrium, and not infrequently extends into the left hypochondrium as far as the midclavicular line. Situated between the portal and systemic circulations, it has many and varied missions, the derangement of any one of which will spell disaster to the health of the individual affected. The liver occupies the unique position of being the only organ performing its work in nonoxygenated blood. Most of its blood supply is venous, coming from the portal system, and but little from the hepatic artery. The blood conveyed by the portal apparatus contains the soluble end-products of digestion, absorbed from the intestinal tract. These products are metabolized in the liver before entering the general or systemic circulation.

As has often been said: "The liver is the most important biochemic laboratory of the body." Its functions are many and diversified. Some of them are undoubtedly not recognized at all, and others are but little understood. Of the familiar ones the most important are the formation and secretion of bile; formation and storage of glycogen derived from carbohydrates, carbohydrate moiety of proteins, and glycerol and possibly fatty acids; and reconverting the glycogen into glucose; reciprocating with the pancreas in maintaining the blood sugar level; metabolization of proteins, and synthesizing of urea; catabolization of purine bodies maintaining nitrogen balance; diaminization of amino-acids; storage of fat from the food and liberation of it upon body requirements, as well as controlling its oxidation. It also has to do with the formation of fibrinogen and clotting of blood. Last, but of great importance, is its ability to destroy or detoxify poisons from various sources, whether absorbed from the intestinal tract or carried to the liver by the systemic circulation as a result of tissue breakdown. It has been proved experimentally that poisons of various kinds, when injected into the body, will cause less damage to the tissues if administered into the portal rather than into the systemic circulation. This is due to the fact that the liver renders such substances less potent.

Heyd aptly says: "Apparently there are at least 4 factors that bring about low-grade liver changes. The first is infection, the second chronicity of infection, the third toxicity of the infectious by-products either by lysis of the bacteria themselves or the toxins they elaborate, and the fourth the catabolic by-products of metabolism. It seems reasonable, therefore, to assume that the liver might exhibit certain disturbed states or functions. In other words, the liver may show an insufficiency in function-hepatargia; or a perverted function-dysfunction; or finally, a complete cessation or exhaustion of function. Probably the primary cause of some of the conditions that we consider metabolic diseases, gout, nephritis, arthritis, may be due to an inability of the liver to protect the body against certain toxic by-products."

Adami among others has shown that leukocytes and bacteria are constantly passing from the surface layers of the intestines into the deeper tissues. He notes there is "a tempor-

ary proliferation of bacteria in the capillaries to which they have been carried, until such time as mechanically or otherwise they set up irritation and reaction. As soon as the tissues react, the bacteria undergo lysis. It is not their proliferation but their death that liberates the toxic substances, which, diffusing out, destroy the higher tissue cells in the neighborhood and simultaneously stimulate the lower connective tissue cells to proliferate and develop an area of fibrosis. We deal, that is, with something beyond local capillary infarct formation. The area of necrosis extends beyond the limit of the territory of the blocked capillary. Its extent can only be ascribed to the action of liberated toxins. What is characteristic of all these cases is recurrence, or, more accurately, they represent not simultaneous infection, but the summation of a succession of minute insults to the tissues, sometimes occurring within a few days or weeks but often extending over years, so that on examination lesions may be discoverable in various stages. What is more, it is evident that the incriminated bacteria gain entrance from various points".

Again Heyd points out—referring to MacCullum's having given iron peptonate to a fasting animal and finding leukocytes containing iron in the walls of the gut and in the liver and spleen—that bacteria are constantly passing into the system from the intestines and as constantly being destroyed, notably in the mesenteric and other lymph nodes and in the tissues, and that under such circumstances there is no infection in the accepted sense of the term, but with the destruction of the bacteria there are liberated their toxins, which produce a low-grade chemical irritation resulting in degeneration of the hepatic cells with fibrous tissue replacement.

Microscopically, according to Heyd, Killian, and MacNeal, the liver changes in the more chronic cases represent an advance in pathologic intensity in keeping with the chronicity of the abdominal conditions, uniform fibrosis is more marked, loose connective tissue is more abundant about the bile ducts and portal veins, and bile stasis is more apparent. Leukocytic and lymphocytic infiltration extends between distorted liver cells which contain vacuoles and are disintegrated. Histologically, this picture is distinctive of this type of hepatitis and does not represent the pathology observed in Laennec's cirrhosis.

The symptoms will vary with the individual patient, depending upon such factors as the type of individual, associated lesions, virulence of both primary and secondary infection, and locations of infections.

The symptoms frequently give no indication of the extent of the pathology, and a thorough examination of all parts of the body should be insisted upon. Some patients with advanced lesions are practically symptomless, while others suffer intensely from the results of minor changes. In private practice the most common signs and symptoms occur in about the following order of frequency: a sense of fulness in the epigastrium relieved by eructating gas, disturbed appetite, constipation, headache, insomnia, drowsiness p. c., nausea, fatigue, painful muscles, painful joints, sallow complexion, jaundice, loss of weight, irritableness, and various skin lesions.

It is often of importance to determine how well certain functions of the liver are carried on, and numerous tests have been devised to aid us in this determination. Some of the most important ones are:

(1) Examination of blood, urine, or feces for bile pigments or their precursors, by Fouchet's test, Ehrlich's aldehyde reaction, Schlesinger's test, Hay's sulphur test, Gmelin's test, iodine test, van den Bergh's test (of value in determining whether jaundice is of the obstructive or hemolytic type), and the icterus index.

(2) Investigation of metabolic functions, by the levulose tolerance test of Strauss, the galactose tolerance test used extensively by Rowe, or nitrogen partition methods.

(3) Test for antitoxic powers, by the Roger's reaction with glycuronic acid, or the indican reaction following a provocative dose of indole.

(4) Tests of hematopoietic functions: coagulation time, estimation of blood lipase, colorimetric methods for estimating fibrinogen, the fibrinogen test of Hurwitz, Widal's hemoclastic crisis test, the global capacity test of Rowntree, Hurwitz, and Bloomfield

(dye injected subcutaneously and recovered from the bile in duodenal contents).

(5) Cholecystography.

(6) Investigation of bile obtained by Lyon's method.

Treatment is first directed toward eliminating all possible foci of infection in other parts of the body, by whatever means is indicated; then of relieving the diseased liver of as much of its infected material as possible. In the absence of contraindications, the latter result is undoubtedly best obtained by biliary tract drainage by the Lyon method. Other remedial measures include correcting dietary faults, recommending sufficient rest and recreation and modern hygienic measures, employing rational psychotherapy, and the use of radiology, hydrotherapy, massage and drugs to meet the needs, as far as possible, of the individual patient.

In a paper read before this association last year, emphasis was placed on the importance of including bile examination in the routine search for foci of infection. Several hundred liver and gall-bladder drainages since that time have served to increase our confidence in this procedure.

ORTHOPEDIC TREATMENT OF INFANTILE PARALYSIS

Arthur J. Davidson, M.D., F.A.C.S.,
Philadelphia, Pa.

At the termination of the epidemic of infantile paralysis in Philadelphia, the Director of Health called together a group of representative orthopedic surgeons and neurologists of the city, for the purpose of formulating a definite outline of the modern treatment of infantile paralysis in the convalescent stages, for the use of the profession at large who would care for these patients. As a member of that committee I shall follow closely the opinions and recommendations advanced by this group.

For a practical consideration of the study of infantile paralysis, the disease can be divided into 4 stages; (1) The acute febrile stage which lasts 4-10 days, during which the paralysis becomes established. (2) The stage of nerve and muscle tenderness and pain, following the fever, which lasts 4-8 weeks. (3) The convalescent period, during which in many cases the paralysis can be improved or even cured by proper treatment, and which lasts from 2-6 years. (4) The stage of permanent paralysis.

During the first or acute febrile stage, the patient is best treated by hospitalization, where isolation, complete rest and necessary therapeutic measures can best be carried out. The management at this time is usually administered by the general practitioner or pediatrist or occasionally by a neurologist. The orthopedic surgeon rarely is called upon to see the patient until this stage has passed. The management during the febrile period is practically that of any acute infectious disease, with certain modifications such as spinal puncture.

Employment of convalescent or adult blood-serum has received considerable recognition. Its value is still debatable. If the serum is given, it should be used as a preventive measure in cases of suspected contact, or in doubtful or established cases before paralysis has developed. If the paralysis has once developed, use of the serum does not seem to have any definite effect upon the severity or retardation of paralysis.

The second stage, that of muscle or nerve tenderness, persists after the patient's return from the hospital, and will come under the supervision of the family doctor. For a better understanding of this stage, it is well to consider the disease in terms of nerve-cells rather than muscles. As long as there is any pain or tenderness, we may be sure that inflammatory changes in the damaged cells in the spinal cord are still present, and therefore all local stimulation, such as deep massage, electricity or exercise, should positively be delayed, because of the danger of increasing degeneration of the nerve-cells. Treatment of this stage is rest—complete rest, both mental and physical. The child should be kept in bed, with strict isolation. The paralyzed parts should be kept warm, either by wrapping them in wool or cotton or by the use of external heat from lamps, hot pads, etc. The paralyzed

limb should be supported in a neutral position, one of physiologic rest, the position half-way between flexion and extension. In the case of a foot or ankle, it should be placed at right angles to the leg; a hand either straight or slightly cocked up; a shoulder supported with the arm abducted at right angles from the body, with the weight removed from shoulder joint. A paralysis of the back or abdominal muscles should be held with the body in a frame in the straight position. These parts can be supported either by splints, sandbags or plaster casts, and many times temporary forms of apparatus are employed to meet the needs of the individual. The importance of the maintenance of this neutral position cannot be overemphasized, for it is at this time that deformities develop. It should be understood that deformities are not due to paralysis of the muscle groups but to the uncontrolled pull of the unparalyzed muscles, which continue to contract when the opposing muscle action has been removed by the paralysis. For example, the most common deformity is foot drop or equinus. This is caused by an overaction of the strong calf muscles when the opposing dorsiflexors are paralyzed. At first these potential deformities are easily overcome, but if allowed to remain, the strong muscles contract and shorten and thus make correction difficult or impossible.

It is difficult for parents to realize that these methods of treatment alone are to be employed during this stage of the disease. They often complain that too little is being done for the child. It should be the duty of the physician to impress upon the parents that, during the stage of tenderness, rest, heat and support alone should be employed, and all local methods of stimulation are positively harmful.

During the third stage, when tenderness has entirely disappeared, active treatment to restore muscle power can be started. Careful massage is of the greatest value. It should be given only to the paralyzed groups of muscles, and should be continued daily for weeks or months. The affected joints should be moved gently in all their directions to stimulate function and prevent stiffness. Electric stimulation may now be given, but *only* under supervision of thoroughly skilled physicians qualified in its use. Only the paralyzed muscles are to be stimulated, and this stimulation should never be given to the degree of fatigue. The unskilled employment of electricity may be positively injurious and delay rather than hasten recovery.

The period of rehabilitation is now started. The patient must be assisted in exercising the weakened muscles. Various types of apparatus may be used to support weakened muscles and prevent deformities. Braces of various materials are the most commonly used form of apparatus. The modern brace is quite different from the heavy, cumbersome appliance of the past. Lighter metals are used, and many are made of celluloid because of its extreme lightness. Elastic straps are used to reinforce the action of weakened muscles, and corrective shoes are used to establish balance and relieve strain.

During this stage, surgery plays a minor rôle. Occasionally a tendon may be cut to permit a better position of a part, or stretching under anesthesia may be permitted as an aid to the other methods of treatment. There is no specific medication. Warning should be given against the use of such drugs as strychnia and arsenic, as they can never help the diseased nerve-cells and may destroy the chances of recovery.

In the fourth stage or stage of permanent paralysis, the management should be undertaken only by a trained orthopedic surgeon. It is now that complicated apparatus is used and various surgical operations are employed, with the object of correcting deformities, restoring balance, relieving strain, and to stabilize insecure and relaxed joints. Many highly specialized methods of operation have been perfected to accomplish the desired requirements in given cases, and remarkable studies have been made in recent years by the orthopedic profession in surgical treatment of this dreaded disease. Most of the deformities can be improved, if not corrected, and surgery is gradually diminishing the necessity for use of permanent supports. If the management was given more careful consid-

eration in the early stages, many dreadful deformities could be avoided, and the necessity for subsequent surgery removed.

ASTHENOPIA IN CHILDREN

S. Creadick Rhoads, M.D.,
Westville, N. J.

Asthenopia in children may be defined as ocular weakness, and it may be the result of refractive errors, termed accommodative asthenopia, or some disturbance of the ocular muscles, classed as muscular asthenopia, or a combination of both. In accommodative asthenopia, the symptoms may be either visual, conjestive or reflex.

The visual symptoms have to do with the variations in vision for distant or near objects. It may be difficult for the child to distinguish objects on the blackboard, while at close range there seems to be no difficulty whatever; this is probably a myopic condition. Or, the condition may be reversed and be due to hyperopia. Accompanying these symptoms there may also be associated drowsiness on reading; indifference to study or, indeed, direct repugnance to work of that nature; and little or no inclination to read books or play games requiring use of the eyes. The children may even complain of irregularities in shape or color of objects, flashes of light, floating specks, or photophobia.

The congestive symptoms comprise inflammation of the lids, conjunctiva, sclera, iris and even uveal tract.

The reflex symptoms are many, and often far removed from the cause. Headache, neuralgia, vertigo and nausea, anorexia, dyspepsia, vomiting and choreiform attacks, are frequently associated with asthenopia in children.

Too much emphasis cannot be laid on the point that a serious error of refraction may exist without any direct ocular symptoms. A child may be suffering from a grave refractive error, usually hyperopic in character, and still be able to read the normal line on the test card. This is due to the enormous power of accommodation that children possess, and is often misleading to the examiner. If a child presents asthenopic symptoms, he should be refracted under a mydriatic regardless of how he reads the test card. If a child can read the normal line after complete mydriasis has been established, then only, after a more careful examination is made for muscle imbalance, can he be said to possess a perfect visual apparatus.

Some of the more remote reflex symptoms are irritability, general nervousness, restlessness when asleep, dreams of an unpleasant nature, contortions of the muscles of the face and eyelids, and, as a direct result of turbulence of the central nervous system, faulty deportment in school and at home.

The effect on the mental aptitude of a child is frequently marked. He is often behind in his studies and usually makes poor grades. He is scolded because he cannot draw a circle when to him a circle may look like an ellipse. A capital "H" may appear to be 2 "I's". Subconsciously the child avoids study because such application invariably results in unpleasant symptoms which he has learned to associate with close work.

In muscular asthenopia, muscular imbalance or heterophoria, the symptom complex is caused by lack of coördination of the ocular muscles. This is a frequent finding and often overlooked. Here again, a child may read the normal line on the test card after complete mydriasis. Even after any existing refractive error has been fully corrected, he still may be suffering from a muscular imbalance of high degree. It may exist alone or together with a refractive error. The symptomatology may be identical with that of accommodative asthenopia. These 2 ocular defects can be separated *only* at the refraction table.

Among the more outstanding symptoms is diplopia, especially when the diplopia is slight so that double images are close enough together to confuse each other and cause blurring and at times vertigo. Amblyopia, or a partial blindness from disuse of an eye, is another frequent finding.

Reflex symptoms induced by the effort made to correct the deviation include pain in the eye, conjunctival irritation, and headache. Headache may be orbital, supra-orbital, tem-

poral or occipital. There may be pains in the neck posteriorly. Occasionally we also find spasms of the facial muscles, and not infrequently digestive disturbances and interference with general nutrition. These symptoms are the result of the strain imposed on the external ocular muscles in the attempt to correct the deviation. If the child does not correct the deviation, he will see double and objects will be indistinct. If the child does correct it, the muscles after a time get tired from the continuous effort. Often we find alternation between distinct vision with symptoms of strain and diplopia and indistinct vision when the strain is relaxed.

Reflex symptoms are especially pronounced when the deviation is so slight that the patient *can* overcome it and does so—with effort. The less the deviation, the greater are its pernicious manifestations. They are also particularly marked when the deviation is inconstant and varies under different conditions of ocular use, because, when deviation is *not* constant, the patient cannot allow for the changing position of the eyes as readily as when the deviation *is* constant. Consequently, the reflex disturbances are greater in heterophoria than in actual squint, and greater in a periodic squint than in continuous.

One of the most frequent symptoms of an existing phoria is the nausea produced from riding on moving vehicles.

All forms of phoria or tropia are disastrous in their action. Any disturbance of binocular single vision invariably results in amblyopia, even to the extent of causing complete loss of vision in one eye. This occurrence is so frequently met in the practice of ophthalmology that it is emphasized in this paper. The fallacy that the child will grow out of this condition has resulted in so many thousands of amblyopic eyes that its importance cannot be overemphasized.

The early detection and correction of asthenopia in children calls for close coöperation of teacher, school medical inspector, family physician, family and ophthalmologist.

MEDICAL ASPECTS OF CARCINOMA OF THE COLON

William J. Mallory, A.M., M.D., F.A.C.P.,
Washington, D. C.

Early symptoms of cancer of the colon are vague. Even the later symptoms are not sufficiently clear to hint at the gravity of the lesion; and yet, when a large number of cases are reviewed, there emerges from the complex nosology several syndromes sufficiently characteristic to justify the special examinations which alone will lead to early diagnosis.

A consideration of cancer of the colon from this point of view is merited by the following facts: (1) Greater familiarity with the early symptoms will lead to earlier diagnosis. (2) Diagnosis is possible earlier than in cancer of other internal organs if adequate examination is made. (3) Cancer of the colon is more accessible to surgical treatment than is cancer of any other internal organ. (4) The incidence of carcinoma of the colon demands more serious consideration by the general profession.

In 527 cases of surgical disease of the ileum, large intestine and rectum, reviewed by Rankin, malignancy was present in 381, or about 72%. The large intestine and rectum produces more carcinomas than the stomach itself. In the Mayo Clinic there were records of 24 cases of carcinoma of the small intestine, 1822 of the large intestine and rectum, 1689 of the stomach.

Age incidence should be mentioned only to point out its lack of value in diagnosis. Cancer of the colon, as of other organs, is not limited to the so-called cancer age, this factor being less important in carcinoma of the colon than carcinoma of any other internal organ; 1/6 of the cases occur between 30 and 40, some under 20, or even 3 years.

In looking for a preventive, it is discouraging to read reports of the simultaneous symmetrical occurrence of tumors in homologous twins. Tumors occurring in homologous twins seem always to be similar, symmetrical, and simultaneous. However, it is of practical im-

portance to point out the significant relation between occurrence of polyps and carcinoma of the colon. They were found to be associated with malignancy in 40-50% of cases.

In working for a diagnosis, it is rarely practicable to make every special examination known to medical art. Symptoms, then, to a certain extent must direct the procedure. But if symptoms are to be of any value in diagnosis, they must be elicited, studied, and interpreted in the light of knowledge of structure and function of the organ involved. "Symptom" does not mean sign, but a falling together as of events.

In the colon several different syndromes are presented, according to the location of the lesion; this is due to the difference in developmental origin, resulting in special differentiation of structure and function. The right half of the colon is the active, functioning, absorptive portion, resembling physiologically the small bowel up to the papilla of Vater, being developed with it from the midgut. It is of large caliber and its contents are liquid. It has the same villi in the embryo, and retains the same blood supply from the superior mesenteric vessels as the small intestines. On the left side, beyond the middle of the transverse portion, the large bowel, sigmoid and rectum are principally a storehouse for formed feces, and absorptive function is minimal. The caliber is small, there is little absorption, and contents are solid.

The character of the lesion varies on the 2 sides. Malignant lesions in the right half of the colon differ pathologically from those in the left. Usually on the right they are large, raw, ulcerating, bleeding growths, which are covered with protuberances resembling granulation tissue. They are situated almost invariably on the lateral wall. Most are at the junction of the cecum with the ascending colon, and make an ideal surface for absorption without obstruction, interfering with the chemistry rather than the mechanics of the bowel. In most cases there is no tendency for the growth to encircle the lumen, which is greater here than elsewhere in the course of the colon. It may go on to perforation and abscess formation before obstruction.

On the left side, growths tend to encircle the lumen of the bowel by a hard scirrhous ring-like formation, and may usually go on to obstruction as the first manifestation. Mechanical disturbance, rather than chemical change or anemia, is the rule. Hence the symptoms produced by lesions in the 2 halves of the colon differ so much that separate consideration aids interpretation.

Symptoms of right-sided lesions may be profitably considered under 3 groups:

(1) Tumor without significant symptoms. Accidental discovery of a tumor in the right side which, on roentgenologic study, exploring, or operating, proves to be malignant. As this group includes patients examined routinely for other unrelated conditions, and before significant colon symptoms develop, opportunity for early treatment by surgery is very favorable.

(2) No tumor, but attack of so-called dyspepsia, mild in degree, indefinite in character, with few localizing symptoms, infrequent, recurrent attacks of colicky, intermittent pains, gaseous distension, alleviated by evacuation, diagnosed as intestinal indigestion, chronic appendicitis, or irritable colon. This group of cases is large and the underlying condition often far advanced when discovered.

(3) Anemia. Anemia is the outstanding feature, and is not associated with visible loss of gross blood. There is some general weakness, noticeable reduction in capacity to work, slight loss of weight and strength. Tumor may or may not be demonstrable even when suspected. Superficial tenderness and pain may be present, simulating subacute appendicitis without a tendency to disappear. Irregularity of the bowels may be observed as diarrhea, alternating with periods of normal regularity of movement. The degree of anemia may reach as low as hemoglobin 25% or 30%. Erythrocytes to 2,500,000. In large ulcerating growth, a mild fever and leukocytosis may be present. The appearance of the patient sometimes suggests pernicious anemia, but the blood picture will lead to exclusion of that disease.

On the left side of the colon, symptoms of obstruction are the presenting feature. These are mild for some time, beginning with constipation. Later, increasing flatulence disten-

sion, with rumbling and gurgling, occurs. As stenosis increases, symptoms become more severe and more suggestive of obstruction, either subacute or chronic. Colicky pains develop. Some patients are impressively accurate in their description of the peristaltic rush above the stenosis, and its arrest at a given point, followed by gradual relaxation and relief. In thin persons, first palpable, and later visible, peristaltic waves, progressing from right to left, may be demonstrated. Carcinoma from the cecal region to the splenic flexure is associated with diarrhea and severe anemia; that below splenic flexure is more apt to be associated with constipation and is without anemia.

Indivdiual symptoms are of little or much value, according to the insight with which they are interpreted. Pain in the abdomen occurs in so many conditions that its pathognomonic character is almost nil. It should be accepted as a warning, and instead of being immediately interpreted, must lead to further investigation. Pain in carcinoma of the colon varies in degree from a vague sense of discomfort to a symptom of great severity, but seldom becomes extreme until obstruction is marked. Rarely, it may be the disturbance which induces the patient to seek medical advice. Early, it may be diffuse, or cause of a pressing or dragging sensation. It is sometimes referred to distant parts to the right or left iliac fossa, or along the course of the anterior crural or sciatic nerves, due to pressure on the intra-abdominal plexuses.

It is especially important to bear in mind that the pain and discomfort may be referred to the epigastrium and interpreted as gastric disease, manifested by cramps, belching, nausea and vomiting, as it is sometimes precipitated or made worse by coarse food or an unusually large meal, for the reason that filling of the stomach often initiates a peristaltic rush in the colon, and also because irritation of the colon often interferes with normal coordinate motor function of the stomach. The pain sometimes moves from one position to another, until it comes to a termination with violent cramps associated with gurgling, relaxation and temporary relief. Rarely, pain is absent until tumor appears.

Long-standing constipation of purely functional or habit character may, by its duration, distract attention and obscure the symptoms of onset of cancer. Of much more practical significance is change of intestinal habit lasting from a week to a month.

Even when obstruction is developing, the symptoms are only intermittently progressive, and one will be misled by inquiry for sudden onset of sharp pain, shock and obstructive vomiting, which occur in obstruction in more proximal portion of the bowel, resulting in dehydration, low blood chlorides, high nitrogen values, and an increase in the carbon dioxide combining power of the blood. The patient may have complete obstruction with comparatively few symptoms except increased peristalsis and continuous distension of the abdomen. Obstruction occurs 6 times as often on the left as on the right side of the colon.

Of all symptoms and signs, a palpable tumor is most significant, because approximately 90% of tumors of colon are cancer. Its detection is not, however, essential to the diagnosis, as many cases run their entire course without the development of a palpable mass at any time. As a caution, it is to be remembered that the sigmoid is often palpable, sometimes hard and tense, in a hypertonic condition. The doughy consistency of a fecal accumulation may assure temporary anxiety, but induced evacuation and repeated examinations will usually obviate mistakes.

Obstructive symptoms, and more especially signs, should be searched for carefully. Although they are rare in right-sided lesions, they are often the first sign of left-sided lesions. Peristalsis, visible or palpable, is, of course, of high diagnostic value when demonstrable.

The value of examination of feces as a diagnostic measure depends upon how it is done. The report from the best laboratory technician, in these cases, is not as valuable as inspection of the feces by the physician himself. The presence of blood, either occult or gross, is susceptible of many interpretations. An evacuation of normal size and shape does not exclude a constricting lesion in the colon or even the sigmoid, because the fecal column is remoulded in the anal canal and, therefore,

a structurally normal stool may be evacuated even when there is partial stenosis present higher up than the rectum. The stool, ribbon-shaped, or rectangular in cross section, is to be observed only when the deformity or spasm is low down or even in the anal canal. Absence of gross blood does not exclude carcinoma of the colon, because the tumor may progress in development considerably before ulceration occurs. Fortunately, erosions at the site of the tumor may occur before actual ulceration of the tumor mass, and cause bleeding, the presence of which is of the greatest importance.

Even in the presence of demonstrated bleeding hemorrhoids, bleeding should not be considered insignificant, for in a large series of patients operated on for cancer of the colon, it was found that about 20% had been previously treated for hemorrhoids within the period of the development of cancer.

When bleeding once begins, it is usually constant; that is, blood in some form is present with every evacuation of the bowels. The amount is not as a rule as great as from duodenal or gastric hemorrhage. It is usually present in recognizable form, with red streaks on the feces, small partially clotted masses, sometimes dark in appearance. Pus is not a feature; its presence either mixed with blood or alone is more significant of proctitis.

Occult blood, especially when positively present, has great significance. Both the benzidine test and the guaiac test should be applied, because the benzidine test is so highly sensitive that a minute amount of blood from any portion of the digestive tract will give a positive result, whereas the importance of a positive guaiacum test is not minimized by the presence of meat in the diet, and always means significant bleeding.

Digital and proctoscopic examination should precede roentgenologic study, for when once barium is introduced, it is several days before the substance is so completely removed as to make proctoscopy satisfactory. X-ray plates are not to be relied upon for recognition of lesions below the junction of the middle and lower third of sigmoid, because in the normal reduplication and tortuosity of this portion, one loop overlaps and obscures another when the contrast meal is given. Therefore, we must depend also upon finger and proctoscope for the recognition of lesions below this point. Proctoscopic examination should not be perfunctory, but with the patient properly prepared, on a suitable table, with adequate lighting, siphonage and inflation when necessary. Arrangements for removing tissue, taking smears and cultures should be at hand. The procedure is not without danger, from local trauma and perforation, especially when lesions are present. Perforation through a damaged wall has resulted in death from peritonitis even when laparotomy and suture was immediately performed.

Above the junction of middle and lower third of sigmoid, roentgenology is our established reliance. In the Roentgen-ray laboratory of the Mayo Clinic, an accurate diagnosis of organic lesions of the large bowel, verified at exploration, was made in 95.6% of cases.

As a rule, the barium enema should be used instead of barium by mouth. Observation of the inflowing mixture under the fluoroscope, with rotation of the patient combined with palpation, gives more accurate information than when examined by the ingested meal. Plates should be taken as a record, and for added information, but barium by mouth not only does not afford the same significant findings, but has been known to induce superimposed acute obstruction, thus adding greatly to the surgeon's problem and the patient's danger.

The filling defect produced by diverticulitis simulates that of carcinoma more closely than that of any other disease. It is spindle-shaped, its contour tends to be serrated in regular portions rather than roughly jagged, and many or few diverticuli are seen in other parts of the colon.

Chronic ulceration colitis, when it involves only a short segment of the colon, may simulate carcinoma in its roentgenologic aspect. Even so, the filling defect produced by this type of lesion is usually comparatively long in extent, the margins of the canal tend to be smooth rather than irregular, and the wall of the involved sigmoid, although obviously thickened, remains relatively pliable. Hyperirritability is usually a pronounced factor. The

longer history and other clinical features, with which you are familiar, will aid in differentiation.

Acute tuberculosis of the bowel is not likely to cause confusion because the tubercular enterocolitis occurs as a complication of pulmonary tuberculosis, which is not apt to be mistaken on account of the known clinical features.

The hyperplastic type of ileocecal tuberculosis, or tuberculoma of the cecum, may resemble carcinoma in history, physcial finding, clinical symptoms, and roentgenologic appearance. The disease occurs in young adults with a differential point of little value. More significant is its involvement of the cecum, and even terminal portion of the ileum. These are rarely involved in carcinoma. There is a longer history, and a palpable boggy slightly tender mass. The treatment being surgical, differentiation before exploration is not so important, but at the time of operation what appears to be hopeless carcinoma may on careful investigation of a section under the microscope prove to be tuberculoma.

Polypoid disease, important in its association with carcinoma, may be distinguished by the method of A. W. Fisher: that is, withdrawal of the barium enema followed by inflation of colon with air.

Thickened retrocecal appendix, with fixation, adhesions, and tumors, presents much less anemia than would be found at that stage in the development of carcinoma, and there is less characteristic deformity of the tumor of the bowels, if any.

The so-called spastic colon has been mistaken both ways. Patients have been operated upon who had no tumor, and patients with carcinoma have been treated medically. Maximum doses of antispasmodic re-examination, and prompt complete history, should differentiate the conditions.

Mucus colitis should be regarded as a symptom only until recognized methods of examination have been applied to include organic disease. Old appendiceal abscess presents tumor, tenderness, bowel disturbance, and loss of weight, but history and examinations will differentiate this from other conditions. Do not interrupt in examination on finding one lesion. For example, postoperative adhesions, gallstones, or diverticuli, may be concurrent with carcinoma of the colon.

Tissue should be removed for histologic examination. Gross appearance alone may sometimes be misleading and lead to the abandonment of a contemplated helpful operation.

Nothing modifies prognosis so markedly and favorably as early diagnosis, for of course it is understood that this means early access to the surgeon. Accessibility of examination, possibility of early recognition, mobility of the normal colon as compared with other organs, are favorable features. The lymphatic supply of certain segments of the large bowel, particularly the right half of the colon and the splenic flexure, is relatively scant, and for this reason distant distribution of malignant cells is not rapid. Carcinoma in this situation is prone to remain local for a long time, although there is a relatively high operation mortality.

Burgess found that 35.6% come to the hospital with complete obstruction. Obstruction is the ultimate symptom in a large majority of cases of carcinoma of the colon, and is generally the cause of death.

Operability during 1930 in cases of carcinoma of the colon was 57.5%.

Numerous complications are due to late decades of life, health being already undermined, and patient predisposed to cardiovascular renal disease.

Peritonitis is most formidable, higher than in gastric or pelvic surgery. Bacterial content is usually fulminating in type. On the left side, blood supply is not so regularly distributed, and, rarely, necrosis occurs following resection due to inadequate vascularization. Leakage is not common.

Postoperative ileus is not common, and is generally due to adhesions to raw surfaces left at operation, or to strangulation of the bowel by a loop slipping through behind the colostomy opening or into some fossa where it is not readily removed by its peristaltic activity. Usually, postoperative ileus which is not due to actual mechanical obstruction is due to a mild type of peritoneal contamination, which subsequently clears up under vigorous treatment, but if accompanied by dis-

tension, nausea, vomiting and the evidences of mechanical blockage, the condition demands operation.

Parotitis of varying degree of severity is seen rather frequently in patients who are not taking anything by mouth. It is manifested by painless enlargement of one or both parotid glands on or about the third day after operation. As the condition progresses, it becomes quite painful, and suppuration may occur with formation of abscess requiring drainage. Preventive treatment: slices of lemon to suck, gum to chew, alkaline mouthwash.

The most common so-called medical complications are pyelonephritis and pneumonia. Hypostatic congestion in the chest may be prevented by keeping elderly patients in Fowler position in bed, and getting them out of bed as soon as possible. Application of urologic technic to bladder condition may obviate the seriousness of urinary infections.

Treatment is of course surgical, but is not limited to operative procedure. Proper surgical approach and maneuver, and individualization in selection of the type of operation to be performed, are topics for the surgeon to discuss, but wise consideration of such factors has greatly reduced mortality. Optimal time for operation, choice of suitable anesthetic, and selection of appropriate type of operation, are of great importance, and must naturally be left to the operator for decision.

Preoperative and postoperative treatment is of the utmost importance. The patient should be hospitalized from the beginning. According to Rankin and Bargen, a diet of 2000-3000 calories of carbohydrates should be given, including principally candy and fruit juices, protein and fat of low residue. Daily examination of urine, for overflow of sugar and sugar examination, should be made. Depending upon the amount of obstruction present, castor oil in doses from 30 to 60 c.c. is given by mouth in some cases. Cleansing enemas of physiologic solution of sodium chloride are given 12 hours later, and repeated every 12 hours until 24 hours before operation. Such preparation takes 3-5 days, depending upon the amount of obstruction produced by the lesion, its situation in the colon, and the general condition of the patient.

If barium has been used in diagnosis, it must be removed thoroughly. A flat Roentgen picture of the abdomen, made 24-48 hours after barium has been given, eliminates the danger of sending the patient to the operating table with barium in the bowel. During the first 12 hours of the last 24 hours preceding the first operation, divided doses of camphorated tincture of opium are given by mouth. These seem to allay peristalsis and to quiet the patient. Patients are urged to drink much liquid up to the 12 hours before operation. During the last 12 hours, the patient is allowed absolute rest; everything is done for comfort and composure. The day after the colostomy, irrigation of the lower portion of the bowel which contains the tumor is begun. Physiologic solution of sodium chloride is used, and irrigations are continued until 48 hours before the second stage or resection, and a simple cleansing enema of the portion of the bowel above the colostomy is given the night before the operation to prevent gross fecal soiling at the time of operation. In older men with hypertrophied prostates and residual urine, particularly if there are rectal lesions, lavage of the bladder is instituted to avoid an ascending pyelocystitis. Normal sodium chloride solution is given subcutaneously and glucose solution; 100 c.c. each hour up to 2000 c.c. in 24 hours may be used intravenously. A vaccine of streptococci and colon bacilli, derived from patients who have succumbed to peritonitis, employed in a large series of cases, has been a vital factor in the reduction of mortality from peritonitis. Bacteriophage in surgery of the colon and rectum has been used preoperatively and is considered worthy of further study.

With regard to radium, Sir Charles Gaston-Watson states that: "After 7 years and 200 applications, I am satisfied that, with our present knowledge, the results of treatment are too uncertain to justify the use of radium as a routine measure in preference to radical surgery in those cases in which there is a reasonable prospect of successful radical surgery. Only when radical surgery is contraindicated on general grounds, or the patient refuses to submit to colostomy and incision, is it justifiable to employ radium."

RECENT ANNUAL MEETING

It has been our custom to present immediately after each Annual Meeting a brief sketch of the most important events thereof and even though we hope to issue the "Transactions" this year as a "Supplement" to the August Journal, we will relate now a few of the most important developments.

We carried in the Journals of April (page 360) and May (page 390) several proposed amendments to the Constitution and By-Laws, introduced at the Annual Meeting of 1932 by the Special Committee on Revision. All of the proposed changes were duly considered and adopted at the first session of the House of Delegates on June 6. The only change which occasioned much discussion, and which ultimately brought about a division, was that which establishes the new office of *President-Elect* and reduces the number of Vice-Presidents from 3 to 2; in other words, instead of having a President and 3 Vice-Presidents, as heretofore, the Society has now, and will have hereafter, a President, a President-Elect, a First Vice-President and a Second Vice-President; and, annually, from now on, the President-Elect of one year's holding will *automatically* become President without further process of nomination and election. This amendment was adopted, and the new situation effected by a vote of 73 in favor of, as against 33 opposed.

At the time set for election of officers, the Chairman of the Committee on Nominations, Dr. John F. Hagerty, submitted a report, nominating the following candidates for the elective offices: President, Frederic J. Quigley; President-Elect, Lancelot Ely; First Vice-President, Marcus W. Newcomb; Second Vice-President, Francis R. Haussling; Secretary, John Bennett Morrison; Treasurer, Elias J. Marsh. All the candidates named were unanimously elected.

Scientific Exhibit. It would scarcely be possible to praise too highly the fine piece of work done in this matter by Dr. E. E. Downs in securing and arranging such an excellent exhibition of scientific material. Unfortunately, the determination to have such an exhibition this year was not promptly made. When other program features were being considered, as usual, just before Christmas, it was thought to be inadvisable, if not impossible, to hold such an exhibition this year; partly because of the labor and expense involved, and partly because Dr. Martland, who had performed the task in 1932, was laboring with the American Medical Association this year and was unable to give the necessary time to the State Society. Furthermore, some exhibits which might have been had here were promised to the A. M. A. So many members, however, soon expressed disappointment at the decision, that the matter was reconsidered and the machinery was set in motion with determination to do the best possible in the line of repeating last year's success. Dr. Downs accepted President Lippincott's appointment as a "Committee of One" and responded to his urgent appeal by throwing himself wholeheartedly into the project. As is invariably the case when a man goes at his job in that way, a notable success was the result. Certainly, this year's exhibition was a creditable affair, and Downs deserves special thanks for his achievement in spite of the many difficulties which had to be overcome.

The Attendance was considerably below normal; less than 700 all told. This was anticipated but is, nevetherless, regrettable.

The Scientific Program was quite up to the standard of previous years, but once again there arose that deplorable situation of having on the last day an excellent program, and the speakers on hand, but no audience. So many had gone home that it was practically useless to attempt holding the last session.

One new feature introduced this year—that of an Exhibition of Arts and Hobbies—proved far more successful than we had dared to hope. The suggestion was first made by the Executive Secretary 5 years ago but not until Dr. William K. Campbell, of Long Branch, agreed to accept the chairmanship of a special committee for the purpose, did we see any prospect of a hopeful inauguration of such plans. President Lippincott gave the proposition a tremendous boost when he appointed a committee of interested individuals, and he and Mrs. Lippincott gave hearty support to the committee throughout the period of its arduous task. The number of voluntary entrants surprised and pleased us, and the variety and character of artistic exhibits surpassed all expectations. We have been promised a detailed description for publication in the Journal, and we hope the Committee will be reappointed and the exhibition continued.

The evening session devoted to Medical Economics, with Drs. Ross, Hartwell, Morrison and Sherman as speakers, was, also, extremely valuable. That program was a fitting close to the work of the Journal throughout the year in presenting our members with a compend of all available knowledge for use in solving the problem of *State Medicine.*

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive it regularly will confer a favor by notifying the Chairman of the Publication Committee.

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THE PRESIDENT'S ADDRESS

We have in recent years made it a custom to publish in the July Journal the Presidential Address delivered in June at the regular Annual Meeting of the State Society, and here-in you will find—as first among the original articles—the Address so recently given by President A. Haines Lippincott. It was brief yet broadly inclusive; excellently written, but equally well delivered. The President gave us in an entertaining manner a comprehensive review of his period in the Presidency of the Medical Society of New Jersey.

We hope each and every member will read what Dr. Lippincott said concerning the profession of medicine as compared with other professions and with business, trades or occupations of all sorts. As a means of enticing, may we quote a few of the more striking phrases?

Said he: "No one chooses this profession with the idea that he will attain great riches, but rather with the thought that, through the medium of medicine, he can do most for his fellow-men. * * * Realizing the sacrifices and accomplishments made by many in the field of medicine, it gives me a thrill to be able to say—*this is my profession.* * * * In comparison with material progress, medical achievements present the most enduring contribution to the age, and it is significant that through this period of economic depression, when things material have crashed about our heads, crushing to earth men who dealt in material things, most men in our profession have gone steadily forward in the even tenor of their ways."

RESPECT OF THE PUBLIC FOR THE PROFESSION

A question raised in the President's Address, and which has appeared frequently and been expressed in various forms, is embraced in the following question quoted from an article written by the President of the Minnesota State Medical Society in 1931: "How does the medical profession actually stand in the estimate of the intelligent, unprejudiced layman who is not in immediate need of a physician's services?" Another form of propounding the question is given thus: "Does the medical profession still hold in men's minds the exalted position of former times?" The answers to this query are, perhaps necessarily, as varied as the guise in which the question appears.

In the Deparmtent of Collateral Reading we are presenting in abstract form some of the views of a physician's wife, concerning the problem, written in a most interesting manner.

Collateral Reading

A DOCTOR'S WIFE SPEAKS UP

Anonymous

(Republished from Harper's Monthly Magazine)

I had had to put the grocer off, saying that I would pay him in a few days. What I meant, but did not say, was that if any of several patients who owed my husband good-sized and overdue bills would only pay him we would pay our own bills with joy. Nora had heard the conversation in the kitchen, and was full of good Irish rage as I explained things to her.

"He'd no business to bother you", she sputtered. "He knows you and the doctor pay your bills. He's in business and he'd ought to know by now that doctors is always slow pay."

Kindly as it was meant, Nora's slogan, "Doctors is always slow pay", was little comfort to me then. And although the saying has become a family joke, I can still feel the bitterness of having had to explain and defend unnecessarily the credit of an honorable and hard-working member of an honorable profession.

As a bride I could not go about broadcasting the domestic economics of a young doctor. But now, after 20 years in his family, I am moved to take pen in hand and make some observations on patients and doctors and the practice of medicine; particularly as no doctors seem as yet to have arisen to discuss in the magazines the criticisms of many recent lay writers. A human and pardonable pride prevents physicians from defending themselves in the public prints, medical ethics or no medical ethics. They are driven to a hurt silence rather than to anger by many of the articles printed; which is noble, to be sure, but not very effective.

To begin with, the question of medicine today is not so simple as it sounds. People talk as if it were all a matter of taking the part of doctors or being against them. As a matter of plain fact, medicine has become a well-established economic institution and, like it or not, we are living in a state of partly socialized medicine. Infectious diseases are controlled by public and semi-public agencies, and industrial and insurance medicine supplement the great free hospital and clinic services. Nearly everyone takes this all for granted as a good thing. Nearly everyone also approves of the public health movements which have not yet developed to the point of becoming a part of city and State organization. All of this progress in health education and control of disease was started and is guided by doctors. No one doubts that the distribution of medical care and preventive medicine is a social and economic question of the first rank; and, contrary to popular belief, medicine is far from blind to the situation, as even a casual glance at recent medical journals shows.

Criticism of medicine and doctors is more likely to be criticism of detail than of general policy. The more personal criticisms fall into 2 classes: those finding fault with the size of physicians' fees, and those finding fault with medical service. The latter includes bitter reports of mistaken and late diagnosis, and criticism of what doctors call "the handling of a case", with circumstantial accounts of disingenuous, high-handed, or pontifical physicians. Among the second class are also those harrowing stories of persons who have had the misfortune to fall into the hands of poor doctors and bad hospitals.

First, the matter of high fees. The doctor in practice has 1 commodity to sell—his time, valuable because of his brains, training, and experience. He may have assistants who take histories and do preliminary examinations, but each patient must take a certain amount of the doctor's actual time. The physician cannot multiply his brains to reach a great many customers as can a manufacturer, a publisher, a farmer, or even a lawyer with a large corps of partners and clerks. His only way to increase his income as he grows in experience and reputation is to increase his fees. There are only 24 hours in each day, and it is physically possible to see only so many patients and to make only so many calls. The patient often does not realize that a doctor who charges high fees is one who refuses to do careless work, who is not unwilling to spend 10-16 hours a day at his work—which is usual among doctors—but unwilling to take care of too many patients, with the consequent haste, worry, and chance of error.

The lay public has been told over and over again that doctors as a class are ill paid, and I suppose it is willing to grant to the statisticians the accuracy of the average-income figures. But the patient who sees the successful physician in his prosperous-looking office, and is annoyed at the size of the bill for something

which, after all, is a mere opinion and cannot be seen, tasted, or handled, may well contemplate the following facts. If a physician is a well-trained doctor and an honorable man, so that he becomes in middle life a reliable, experienced, and successful practitioner, he must, after his 10 years of training in college, medical school, and hospital, still have had either some capital to live on while getting established in practice, or have starved till he was 38 or 40 years of age; if poor, he must not have married till he was 35 or 40, or else his wife must have money or a lucrative profession of her own; he must not take salaried jobs, even a half-time one, to keep him alive, except in connection with medical education, if he wants to be a first-class practitioner; he should do some research for several hours a day while his practice is small; he must do much unpaid work from the first, in clinics, in hospitals, and for private cases; he must not advertise or make money from a discovery, a patent medicine, or some instrument he may happen to invent; also, he must never appear to be unsuccessful. To these conditions must be added the important fact that a first-class doctor has, with luck, from 15-20 years between the time he is 40 and his early death (the average age of death, according to the figures, being 60) to make money enough to educate his family, provide for his old age, if he lives to have one, and for that of his wife.

This economic heyday of the doctor's career, when the fees are high, might not be so bad if life did not also after 40 become so complicated for a doctor of any public spirit. This is true in villages, towns, and cities of every size. A doctor is expected, and expects, to sit on all kinds of committees, to be active in all kinds of medical, social service, and public health organizations.

In the large cities where most of the criticisms of medicine are heard, the matter of medical education complicates the situation. We are at present in a transition stage between the old apprentice system of teaching medicine and the new ideal of well-paid, full-time men for the teaching of practice as well as of theory; much clinical teaching is still done by men who are also specialists or general practitioners. It is not unusual for a doctor to teach 15 or 20 hours a week in medical school and hospital (a schedule which would be considered good full-time teaching in any college), keep long daily office hours, and make calls, engage in consultations, or attend meetings of various sorts until midnight every day. Here again the vicious circle operates, to the confusion of the well-meaning patient. Because the doctor spends so large a part of his day in poorly paid teaching, in his unpaid public practice in the hospital, and in public health work—some or all of which are necessary for the broad experience which the public demands—he must earn his living from his private practice, in a comparatively few hours a day.

Many criticisms of medical service are no doubt individually valid. A doctor who has made a patient miserable by dissembling unsuccessfully his own lack of knowledge, by actual neglect, by too casual attention, or even by rudeness has fallen far below the standard that any good doctor sets himself. There are 156,440 doctors in the United States of America, and among them are bound to be some men who are less scrupulous, less careful, less honorable than the average. The mistake so often made by the victims of unfortunate medical and surgical experience is that, most understandably, by means of a common fallacy they have generalized from one instance, and thus indicted a whole profession from a single physician's mishandling of a single case.

The people who complain of the results of bad treatment in an emergency are really paying medicine a high compliment in their trustfulness. They expect, by their own statements, excellent treatment from any doctor called in suddenly in any emergency in any quarter of any city. They have not had forethought enough to acquire a regular physician by looking up the local doctors in the medical directory or calling up the county medical society or a recognized hospital and getting the name and address of a good doctor near their home.

Hospitals and their sins I know very little about. The one obvious fact about hospitals is that good medical care is expensive, whether paid for by city, State, private endowment, or the patient himself. Blame for the high cost of nursing care, too, is often laid at the doctor's door by people who 20 years ago would have been quite satisfied with the amateur attentions of their relatives but now expect 2 nurses as a matter of course. All costs of treatment have increased with medical progress.

Now for the main and most serious criticism of physicians—that of wrong and mistaken diagnoses. In the first place the patient is very apt to ignore the element of time in diagnosis. The fifth or the twenty-fifth doc-

tor who sees a case and makes the right diagnosis may have been called in just as the disease had developed to the point where the first one could as readily have recognized it. This time factor is almost as important as it ever was in the practice of medicine, and the criticism that a doctor is slow in making a diagnosis is often unfair. The family of a very sick patient do not and could not, even with a course of daily lectures, know the constant elimination of symptoms, the narrowing down and differentiation of their meaning at successive stages of disease which the doctor's quiet watching of the case conceals.

Everyone is familiar with the fact that the scope of medicine and surgery has increased enormously in our own generation. Thirty years ago one of the most famous and skillful physicians in America ran his office in this way: whatever he could find out by his eye and ear, unaided by any instrument except the stethoscope (and the facts shown by a urinalysis when specially indicated), formed his basis for diagnosis. The collection of this information did not take very long, and the famous physician would often see 30 or more patients in his office hours. The internist today can see and hear and suspect just as much as the doctor of 30 years ago, but he cannot be content with probabilities when new methods of examination may make them certainties. Where he can have his suspicions confirmed or dispelled he must as an honorable scientist ask for data more accurately collected.

As every doctor knows, a physician has to be liked; must, in the common phrase, "sell himself", "put himself over" with his patients. The first reaction of the patient is always "I liked Dr. Blank", or the contrary. Comments on his work may follow, but the personal reaction always comes first. And it seems sometimes that patients are much more interested in whether or not they like the doctor than in what the doctor knows and can do for them. Medical knowledge and personal charm often go together, but not necessarily. When there is knowledge and little charm the doctor suffers and the public loses. When there is charm and little knowledge the patients and their families are frequently satisfied even to the point of unnecessary death, and unfortunately the doctor is frequently esteemed and successful. The blame for this situation cannot be said to be wholly with the medical profession. It is the patient who is the free agent.

So far I have not gone into the moot question of specialists. Here again, though several books could be written upon it, perhaps my observations after listening to both general practitioners and specialists for years in their occasional hours of ease may be of interest. I have gathered that the scope of medicine is now well beyond the bounds of any one man's lifetime or brain. There are also many subjects in medicine in which the processes, not only of research technic but of actual reasoning, are beyond the intellectual capacity of all but a few brilliant minds.

In spite of these tremendous reaches of knowledge, however, there is no reason why a general practitioner cannot be as competent and useful as ever. His difficulty is to know enough to know when he needs to call in the specialist. The patient's difficulty is often that from a confidence in expert knowledge, he goes from specialist to specialist as symptoms arise, never getting from any one doctor the intelligent supervision that can come best from one person familiar with not only all the medical facts but the personality and living conditions of the patient. The ideal state of affairs, no matter how socialized medicine develops, is for each patient to have a personal physician, a real "medical adviser", who may very likely have a specialty of his own (no doctor can avoid at least a special interest in some one subject), but who knows the patient well and sees him at intervals. Whatever he can treat he treats himself. When he needs more help than his time, experience, or equipment in either technical assistance or apparatus can give him, he sends the patient to a specialist for an opinion. As a matter of fact, most specialists, surgeons included, have a few families for whom they act as general medical advisers over many years.

Lay fallacies, under which I must say physicians stand up with surprising good nature, are often amusing. The lady who, again most illogically arguing from one case to a generality, blithely diagnoses and prescribes for her friends over the tea cups is merely funny, if she does no harm. Her knowledge of physiology could be put on a pin point, but she can be as dogmatic as the most profound of professors.

Of the rich and arrogant patients there is little to say. Their physicians, no matter how unwilling, and with how much loss of self-respect, are obliged to take account of the atmosphere of flattery and the assumption of

infallibility that surrounds them. To continue to treat them, a doctor must develop a manner analogous to that of the wily race who "fool the white folks" as a matter of course, in order to maintain pleasant relations and a steady flow of the means of existence.

Unreasonable patients there are in every scale of living. There are also the patients who wait all day, half sick, and call the doctor only when he comes home to dinner. If the delay is due to thrift, they should be charged double rates after 6 o'clock; if to consideration of the doctor, they should realize that an early call, which may forestall the necessity of later ones, and is made in the course of the doctor's day's work, is far less trouble for him than a special expedition in the evening.

It is not a coincidence that the most difficult patients to treat are of the class that are receiving the most consideration nowadays among constructive critics of the system of medicine. Those well-educated, intelligent (although not medically informed) people, with college educations and small salaries, are a source of far more worry and dismay to doctors than they realize. They usually come from the doctor's own kind of family and are pleasant and delightful as patients. They have ambitions, in their own lines, like his own. They exchange interesting bits of professional information with him. They have eager, active minds and want to know all about everything in the office and why everything is done for them. Without meaning to, they take up so much time and require so much attention and understanding, and they can pay so little in proportion to what they need, that the doctor is obsessed with their difficulties. They, of all types of people, understand and appreciate first-class medical service. But they cannot pay for it. Certainly the individual doctor cannot afford to make them a present of it. What is going to happen to them, I do not know. They are the great problem of the individual doctor, as of the whole profession, just as that horrible item in their own budgets, "Health", is the great problem of their own domestic economy, even when some soft-hearted doctor, who in proportion to his expenses is probably as poor as they, has shaved his bills to a sum they can bear to contemplate.

In the discussions of the relations of patient and physician there is always much talk about treating the patient as well as the disease. The profession has been made responsible on this count for the growth, roughly synchronous with the expansion of medical knowledge, of the popular mystical cults and pseudo-medical professions. One point the public has overlooked. Many patients, difficult because of mental and emotional troubles of their own, need very little treatment for organic disease and much treatment of their mental health. They are introspective and suspicious, and need much more of the doctor's time than some other patient who is much sicker. Such patients often stay happily for many years with a physician who treats them as persons far more than he ever treats any of their physical ills. That such patients have large bills is inevitable, and no evidence of exploitation on the part of the doctor.

The profession of medicine is getting away from the over-sentimentalization it has endured for centuries. But unfortunately such pictures as that of the wise but poverty-stricken old country doctor of fiction, or even the young altruist such as Queed, have been superseded in people's minds too often by a picture of a hurried, silent man in a white coat, who is quiet and businesslike, and charges large amounts for ambiguous findings. I often find myself wishing that everyone who ever criticizes a doctor could go to the New York Academy of Medicine any night in the week and see a part of that education of its members which medicine, alone among the professions, carries on as a matter of course. Here one finds doctors of all ages, but mostly young ones, hurrying in with their bags between dinner and their evening calls—alert and interested, listening for hours to papers, discussions, and questions. A name flashes on the indicator behind the speaker, and a man or woman slips quietly out to the telephone. Long, carefully reasoned papers, lantern slides of intricate charts and tables seem to be followed as attentively at 11 o'clock as at 8.30. The doctors are tired, many of them are worried; but their obvious passion to know more keeps them in a state which to persons of any less intellectually exciting and dramatic pursuits seems thoroughly enviable.

I once asked a doctor who were his best patients—the pleasantest, the least troublesome, the ones with whom he got the best results. Without hesitating, he said: "Those who had a good doctor when they were children."

Lighthouse Observations

PAYING FOR THE AIR WE BREATHE

Two gentlemen, names Davis and Carrier, concentrate for 25 years on—"It's Not the Heat, It's the Humidity"—and produce: (1) New profits for industry; (2) unwilted white collars; and (3), if the customer be domestic-minded, a comfortable home. (World's Work, June 1932, pp. 42-47.)

Mr. Charles William Galloway, Vice-President in charge of operation and maintenance of the Baltimore & Ohio Railroad, reclined, unrecognizable under a ruching of lather, in a Baltimore barber's chair. Into the next chair, presently, dropped Mr. Jesse Hood Davis, B. & O. Chief Engineer of electric traction. Wilted and worn after a humid night in the St. Louis sleeper, the tall Arkansan lacked his customary immaculacy.

"Uncle Dan" turns the trick. Between towels, the executives discussed the weather derogatorily. Was it hot in St. Louis, Mr. Galloway unguardedly inquired. It was not only hot in St. Louis, Mr. Davis assured him, it was insufferable on every Pullman car within 1000 miles of St. Louis; no wonder railroad travel dropped off to nothing in hot weather. The remedy, Mr. Galloway already had correctly guessed, was air conditioning—Mr. Davis' hobby for 20 years.

Vainly, Davis had tried many times to extract an appropriation for an experimental B. & O. car. With just a little money, he had pleaded, he could do something about the weather. This time, due doubtless to the heat of the day, the idea fired Mr. Galloway, and soon (July, 1929) Davis was able to rig up an old day coach as a test car. In April 1930, the *air-conditioned dining car, Martha Washington,* made its début, and, in May 1931, the B. & O. introduced the *first air-conditioned complete train,* the New York-to-Washington Columbian.

So keen and immediate was the traveling public's appreciation, that, 2 months later, the B. & O. issued a second edition of the Columbian, which for the stagnant summer of 1931 showed a passenger-traffic gain of 600%.

This season Daniel Willard's pioneering road will operate 119 air-conditioned cars, or 3 times its 1931 facilities. Other carriers have in service or on order, according to Railway Age, more than 80 additional A-C coaches. As most railroad officials already recognize, conditioned-air is a refinement every major road, for its own defense, must soon adopt. Offensively, it is a salubrious gas with which the inroads of airplane and motorcar upon rail passenger traffic may be met and turned back. The steam carriers thus are learning, thanks to Mr. Davis, what innumerable other industries long have known; that conditioned air is an invisible but valuable aid to business as well as comfort.

Closely allied in usage with refrigeration, air-conditioning has been adapted in the past quarter century to the needs of scores of industrial and other establishments. To processes of textile, tobacco, confectionery, baking, printing, leather, chemical, cereal, paint, photographic film, terra cotta, and other manufacture, and to accurate laboratory testing as well, conditioned air now is virtually indispensable. Dependent on it for comfort are numberless theatres, sound motion picture and radio studios, hotels, department stores, restaurants, steamship dining salons, hospitals, and government buildings—these last from the halls of Congress and the President's executive offices in the White House to the British secretariats of Delhi and Bombay.

Adoption by the railroads of air-conditioning did not, however, benefit them alone. It also gave engineers the necessary strong incentive to develop small, less expensive, and more flexible A-C units and helped largely to prepare the public for an imminent reception of such equipment in its homes, stores, and offices.

Symptoms are now manifold of a popular interest in air-conditioning, which equipment manufacturers hope to nurture into a "boom". Statisticians declare that there is an "ultimate" $5,000,000,000 home and commercial market for air-conditioning, an industry which, they hazard, may lead business out of its morass as the automotive industry did in 1922. Discounting by half, there remains a potential demand perhaps equal to that for domestic refrigeration, a rich market in which a dozen or more manufacturers now are busy staking claims.

"Your Body as a Tea Kettle." The science of air-conditioning of thermal engineering, often confused with mere cooling, embraces control of 4 fundamentals: the air's temperature, humidity, cleanliness, and circulation. The latter 2 factors are more or less constant the year round, the former 2 variable seasonally for the reason that hot air is capable of holding more moisture than cold air. To achieve indoor comfort, therefore, it is generally necessary in Summer to reduce both temperature and humidity and in Winter to raise them. The physiologic reason is simple. The human body is like a tea kettle, constantly exuding heat and moisture for the surrounding air to absorb. If the air is too warm and moist, as in Summer, its absorptive capacity is low and we swelter. Bromidic but true, it's not the heat but the relative humidity (ratio of the air's moisture content at a given temperature to complete saturation) that hurts. On the other hand, if the air is too warm and dry it absorbs bodily heat and moisture too rapidly, the skin parches, and we languish. This condition is common indoors in Winter because heating air without adding water lowers its relative humidity. Thus, if outside air of 31° temperature and 70% relative humidity (New York Winter average) is heated without humidification to a room temperature of 70°, its relative humidity drops to 17.5%; the equivalent of a sunny day in the Sahara.

Scientifically conducted tests by the U. S. Public Health Service, and the American Society of Heating and Ventilating Engineers have established a 68 or 70° temperature with from 35 to 45% relative humidity as the most healthful and comfortable indoor Winter atmosphere. To accomplish its quadruple functions, 4 elements are necessary to Summer air conditioning: (1) a fan to draw in and mix outside and inside air; (2) a cloth, wire, or spray filter to cleanse it; (3) a cooling surface—consisting of coils through which a liquid or gaseous refrigerant circulates, or a spray of refrigerated water; (4) suitable ducts or vents to distribute evenly and without drafts the air thus cooled. Winter air conditioning is accomplished by the same equipment, the sprays and coils then functioning to humidify and heat the cooler, drier air. Oxygen, about which so many people worry, can take care of itself. Into even a well-constructed house, thermal engineers contend, enough fresh air seeps to provide a complete change of atmosphere every hour. A constant stream of new air into the conditioning system is not regarded as necessary to health or comfort.

Air-conditioning originated, however, not as an aid to health or comfort but as an ally of com-

merce. Its initial application was to textile fibers, which are best handled in an atmosphere of high humidity. Due to this requirement, it was deemed impractical prior to 1850 to spin or weave industrially in any save a moist climate such as that of Fall River, Mass., or Lancashire, England.

Comfort A By-Product. With the introduction of high-speed machinery so much heat was generated within the mills that naturally moist climates no longer sufficed. To attain the requisite humidity, manufacturers then began to use steam pots and later atomized sprays of water. Of some help was an air washer, patented in 1897 by Joseph McCreary, of Cleveland, which, although designed primarily to purify, also cooled and humidified the air. In 1906 the art was enriched by 2 contributions: Stuart W. Cramer, of Charlotte, N. C., invented an automatic humidity control, and Willis H. Carrier devised an improved air washer which not only brought air to the saturation point but also controlled automatically its temperature and humidity.

Carrier, who now directs the $10,000,000 organization bearing his name, was at the threshold of a notable career in thermal engineering, a little-explored realm of science. The Buffalo Forge Company, which he joined upon graduation from Cornell, in 1901, soon found that a great research engineer was being subverted to make an ordinary salesman of fans and air heaters. Transferred to its laboratory, Carrier became Chief Engineer of the company in 1906, and, in 1911, published his determinations on the subject of humidity in a monograph (Rational Psychrometric Formulae) which, translated into many languages, became the foundation of modern air conditioning. His services to the art were rewarded last year by the City of Philadelphia with a John Scott medal.

In 1915, with J. Irvine Lyle and others, Carrier founded the Carrier Engineering Corporation which, in 1930, consolidated with the Brunswick-Kroeschell Company, of New Brunswick, N. J., and the York Heating & Ventilating Corporation, of Philadelphia. Specializing, respectively, in air conditioning, refrigeration, and manufacture of air heating and cooling units, the 3 companies combine to form a world-wide and integrated thermal engineering, manufacturing, and sales organization.

One of Carrier's diversions is golf, the others hunting and fishing, in which he revels at his camp on Trout Lake, Ontario. It was on the links, however, that Carrier first encountered Jesse Davis, then (from 1901 to 1905) a draftsman for the Pennsylvania Railroad but already keen for air conditioning trains. As engineers they discussed the problem but developed nothing practical until Davis, armed with a B. & O. appropriation, came back to Carrier's in 1929. Together they produced the original A-C diner, the Martha Washington. Recently Carrier perfected a new railroad A-C unit which, by use of the locomotive's steam pressure, cools water to 40 or 45° Fahrenheit and, therefore, requires no chemical refrigerant in its coils. Similar units now are installed on 22 cars—the entire transcontinental dining-car fleet—of the Atchison, Topeka & Santa Fe and on several Missouri, Kansas & Texas diners.

While the development of refrigeration by steam was proceeding, chemistry did not mark time. Working under the joint auspices of General Motors (Frigidaire division) and du Pont, Dr. Thomas Midgeley, Jr., inventor of ethyl gasoline, early in 1930 produced a new gaseous refrigerant which he called freon, or F-12, for short. Chemically, its full title is dichloro-difluoromethane. By either name it is odorless, noninflammable, and more efficient than older refrigerating mediums; its toxic qualities, in the presence of extreme heat, are yet a matter of dispute. For freon's manufacture and sale, du Pont and General Motors formed the Kinetic Chemical Corporation. Its best customer is Frigidaire, which this year entered the air-conditioning field. Aiming at the market consisting of homes, offices, restaurants, specialty shops and small stores, it offers a new adaptation of the Frigidaire refrigerating unit which, from a remotely installed electric compressor, supplies the cooling medium for one or more A-C cabinets of its own make.

Warm, but in a Cold Room. Other refrigerator and heater manufacturers also are branching out into air conditioning. General Electric has quietly marketed for 2 years one small A-C model whose compact cooling mechanism is self-contained within a hermetically sealed metal drum; meanwhile, G. E. technicians are developing additions to the present limited line. Westinghouse A-C equipment is just now emerging from the wonder-working laboratories at East Pittsburgh. An experimental dining car has been equipped and others doubtless soon will follow. For homes and stores, Westinghouse is developing room coolers, one or more of which may be connected with a central compressor of suitable capacity. Much study is being given by its research engineers to the problem of home heating and cooling by electricity. Now they are working on a scheme of "low temperature radiation" which, achieved by wired wall panels, is said to render lightly-clad occupants of a room comfortable even in a 40° temperature. The operating principle is that of the wireless antenna, the body attracting heat waves as wires do radio waves. The system is economical, reducing by perhaps one-third, it is estimated, the cost of heating.

Entries Grow. More than a year ago, Copeland air-conditioning equipment, not unlike that of Frigidaire, made its bow, and last October Kelvinator entered the field. Holland Furnace and the American Blower Corporation also produce A-C systems, while American Radiator (parent of American Blower) and the Timken-Detroit Company are marketing humidifiers only. Interested, as well, in one or more places of air-conditioning are the A. C. Gilbert Company, Air Way Heating Company, Corozone Company, and Airite Corporation, with others qualifying almost weekly.

Besides Carrier, the other A-C giant, entrenched by more than 50 years of experience in industrial refrigeration and air-conditioning, is the York Ice Machinery Corporation, of York, Pa., whose sales and engineering facilities reach every continent.

For Homes When Costs Come Down. Equipper of more than 100 coaches for the Baltimore & Ohio, York adheres to the principle that each car should carry a self-contained, fully automatic A-C system not dependent upon other cars, the locomotive, or terminal facilities for its operation. Such flexibility is demanded, York engineers concluded after long experiment, to meet the exigencies of switching, stop-overs and pre-cooling, for occupancy. Accordingly, they developed a satisfactory design as they had for more than 200 other separate and distinct applications of refrigeration. Once the final engineering problem of air-conditioning has been mastered, its success in attaining a wide market will hinge, of course, upon cost. This now is admittedly somewhat high, but it is declining and will drop further as the volume of manufactured equipment increases.

Book Review

INTERESTING NEW BOOKS

Adhering to the policy we adopted several years ago we are mentioning such of the new books coming under our notice, through the courtesy of publishers, as are seemingly of most importance to our members and making brief reviews of only those few which for one reason or another appear to be of special import to that same group of possible readers.

Of the Everyday Practice Series, published by the J. B. Lippincott Company and edited by Dr. Harlow Brooks, with the object of furnishing the general practitioner with usable, modern, authoritative knowledge concerning special topics, we have received 4 volumes, as follows: (1) "Functional Disturbances of the Heart", by Harlow Brooks; (2) "Gastro-Intestinal Tract", by William Gerry Morgan; "Orthopedics of Childhood", by William L. Sneed; and, "Posture", by Frank D. Dickinson. To this set of 4 books certainly a reviewer need do no more than refer to the names of the authors linked to their respective medical topics as a guarantee that these books are worth having among one's live reference books close at hand for immediate recourse.

From the Gorham Press, Richard G. Badger, comes a work entitled *"A New Approach to Dietetic Therapy"*, by Eugene Földes, formerly of Budapest, now of New York, which deals with the metabolism of water and minerals in the various diseases.

"Health History; Personal and Familial", by Charles S. McGivern, M.D., Atlantic City, N. J.

If this contribution from the pen of a well known Atlantic City physician, and an active member of our own State Medical Society, receives anything like the degree of favorable reception it deserves on the part of the public, it should soon alter materially the traditional views of laymen regarding health and disease.

The author emphasizes the need for educating the masses—the entire population of the nation—to the point, at least, where the people can grasp what the health authorities essay to impart in their campaigns for health conservation.

The idea of making each of us *the keeper of his own health and genealogic record* is novel, and it impresses us as being an especially valuable contribution to the present fight for longer life through better health. The Editor, through an intimate acquaintance with Dr. McGivern, knew something of this work in advance of its publication but, even with that advantage, did not fully appreciate either its immediate significance or future possibilities until he had seen it in finished form. For recording accurately the complete history of the individual, and much about his family, as to health and disease, it is the cleverest device we have seen or heard about. It has also the great merit of—simplicity. The text is lucid and the outlines sufficiently comprehensive to require the recording of all information of practical value. Indeed, it seems to be, on the whole, a meritorious work which may have far-reaching influences. Particularly do we recommend it to the attention of those interested in promoting periodic health examinations. Also, it has a distinctive field of usefulness wherever the family physician can induce newly-become mothers to start their baby's own record book and keep it up-to-date until such time as the child has been trained to recognize the importance of its continuous development.

"Surgery, with Special Reference to Podiatry", by Edward Adams, M.D., Professor of Surgery in the First Institute of Podiatry, New York City, is a text-book for chiropodists, and seems to be worthy of endorsement. Affections of the feet have created a new interest for both the patient and the physician in recent years; especially since so many States have established Workmen's Compensation laws. The number and variety of injuries of the feet occurring in factories, have caused physicians and surgeons to look about for instruction as to their proper treatment, and as chiropody advances and threatens to become another *specialty*, we begin to visualize a possible conflict with orthopedics; even now there is talk of an over-lapping of their respective fields of labor. It may be recalled that a definition of the word *chiropody* which would enable one to determine readily the legal limitations of practitioners licensed to work in this field, has been sought in our Courts and the Legislature for several years past. A definition acceptable to the Chiropodists, the State Board of Medical Examiners and the State Medical Society was embodied in a new law which was passed only last month. How it will work out remains to be seen.

(To be continued)

Woman's Auxiliary

Essex County

Reported by Mrs. Richard M. Rogers

The Annual Meeting of the Essex County Auxiliary was held on May 22, at the Newark Academy of Medicine, the meeting being preceded by a Luncheon of the Executive Board, at the Hotel Douglas.

The business meeting consisted of reports of the chairmen of committees and the President's final report. Delegates for the Annual Convention at Haddon Hall, Atlantic City, June 8, were appointed. Announcement was made of an Invitation Bridge Party to be held at the Nurses' Home of the Newark City Hospital on June 14. This is planned as a part of the membership drive.

Mrs. J. A. Donahue, Chairman of the Nominating Committee, presented the following list of nominees, and they were all unanimously elected: President, Mrs. Francis J. McCauley; President-Elect, Mrs. Don Epler; Vice-President, Mrs. R. H. Young; Recording Secretary, Mrs. K. C. Forsythe; Treasurer, Mrs. H. J. Wallhauser.

Nominations were asked from the floor to replace the 2 retiring Councilors, and Mrs. G. Braun and Mrs. H. A. Schachter were elected for a term of 3 years.

A comprehensive Survey of the Health Agencies of the State, and their functions, was prepared and presented by Mrs. George A. Rogers.

A very delightful Program of Entertainment was presented, with the following participants: Mrs. Ruth K. Mills, Miss Sarah Hill, Miss Helen Muriel Stickel and Miss Gladys Burns. Tea was served in the parlors of the Academy.

Ocean County

Reported by Mrs. Eugene G. Herbener

The regular Spring Meeting of the Woman's Auxiliary to the Ocean County Medical Society was held at the home of our President, Mrs. Alfred Woodhouse, Toms River, Friday, May 19, at 3 p. m., with the following members in attendance: Mrs. V. M. Disbrow, Mrs. Frank Brouwer, Mrs.

Blackwell Sawyer, Mrs. E. G. Herbener and Mrs. Woodhouse.

The Treasurer's report was received and filed.

Matters pertaining to the local Auxiliary were discussed.

A rising vote of thanks was extended Mrs. Woodhouse for the pleasant afternoon spent at her home.

A motion to adjourn was approved.

Somerset County

Reported by Mrs. E. A. Levy

A regular meeting of the Woman's Auxiliary to the Somerset County Medical Society was held June 15, at the Nurses' Home of the Somerset County Hospital.

Mrs. Ely, the newly elected President of the Auxiliary, appointed her committees for the year and gave an account of the high lights of the State Auxiliary Convention. Mrs. Renner's report of the Atlantic City Convention was read and discussed. Both Mrs. Ely's talk and Mrs. Renner's report proved very interesting and illuminating to those among us who were not privileged to attend.

After a very brief business meeting, there was a motion to adjourn until the next regular meeting in October.

At the close of the meeting, the women joined the doctors in listening to an illustrated lecture by Mr. White on the relation of electricity to the practice of medicine and surgery.

County Society Reports

ATLANTIC COUNTY

L. M. Walker, M.D., Reporter

The regular monthly meeting of the Atlantic County Medical Society was held May 12 at the Chalfonte Hotel with 45 members present.

Drs. M. B. Holoman and Cleary were accepted as members of the Society.

Dr. W. Blair Stewart gave a brief outline of the program for the coming Annual Meeting of the State Society, emphasizing the meeting of the Maternal Welfare Committee on Friday, and urging every member to attend and to register early.

Dr. W. E. Darnall reported progress for the Library Committee.

Dr. W. P. Conaway reported that the Broadcasts over WPG were for the season finished.

It was decided to accept the plan of the Emergency Relief Administration, with fees of $1 per office visit, $2 for house calls; itemized bills to be sent to the Relief Commission for payment; hospitalization in public wards also to be taken care of.

Dr. Silvers said that it should be definitely stated in accepting this plan that it was *purely an emergency measure.*

The Scientific Program was presented by Dr. Thomas Klein, Associate Professor of Medicine in the Graduate School of Medicine, University of Pennsylvania, and Chief of the Medical Department, Presbyterian Hospital, Philadelphia, on "Visceral Syphilis"; and Dr. Jay F. Schamberg, Professor of Dermatology and Syphilology in the Graduate School of Medicine, University of Pennsylvania, and Dr. Carroll S. Wright, Associate Professor of Dermatology and Syphilology in the Graduate School of Medicine, University of Pennsylvania, and Professor of Dermatology and Syphilology in Temple University Medical School, on "The Modern Treatment of Syphilis".

These papers were elaborately presented by their authors and ably discussed by Drs. Barbash, Scanlan, Davis, Scott, Silvers, Axilrod and Krechmer.

The Reporter announced publication in the May issue of the Archives of Pediatrics, of an interesting paper by Dr. E. Harrison Nickman, entitled "Present Status of B. C. G. Vaccination".

BERGEN COUNTY

Second Councilor District Meeting

Spencer T. Snedecor, M.D., Councilor

This annual conclave of the Officers and Delegates of Passaic, Hudson, Sussex and Bergen Counties was held at the Hackensack Golf Club, in Oradell, on May 17.

About a dozen men enjoyed 18 holes of golf in the afternoon. At dinner there were 30 present while another dozen drifted in afterward.

The after-dinner program was as follows:

"The Burden of the Care of the Sick and Indigent on the County Tax-payer", Samuel Alexander, Bergen.

"An Explanation of the Budget of the State Society", Wells P. Eagleton, Newark.

"The Plan to Coöperate with the Emergency Relief Administration", Frederic Quigley, Hudson.

"A Basic Attitude Toward the Report on the Costs of Medical Care", F. W. Wilbur, Sussex; B. S. Pollak, Hudson; Wayne W. Hall, Passaic; E. N. Huff, Bergen.

ESSEX COUNTY

Testimonial Dinner to William H. Areson, M.D.

More than 90 friends of Dr. William H. Areson, of Upper Montclair, were present at a "Testimonial Dinner" tendered him by his professional colleagues Friday evening, June 16, at the Montclair Golf Club.

The thought behind the affair was to demonstrate to him in some way, during the rising crest of his influence, the esteem in which he was held by his colleagues.

The invited guests were: his 2 sons, William H. Jr. and Robert; John F. Areson, D.D.S., Montclair; Henry C. Barkhorn, Newark; Edward K. Brass, Upper Montclair; Oscar L. Carlson, Mayor of Montclair; Alfred T. Gibbs, Upper Montclair; Thomas W. Harvey, Orange; Frederick Hoadley; David A. Kraker, Newark; Carl G. Lehmann, Newark, Chairman, Committee of Isolation Hospital; Howard F. McConnell, Upper Montclair; William Mungle, Retired Supervisor of Board of Freeholders; Frank W. Pinneo, Secretary, Essex County Medical Society, Newark; Ernest A. Reed, Supervisor of the Board of Chosen Freeholders; William P. Shirreff, D.D.S., Upper Montclair; Ellis L. Smith, Superintendent, Essex County Isolation Hospital, Belleville; Alfred Stahl, Newark; J. Roland Teed, Verona; Joseph G. Wolber, New Jersey State Senator, Upper Montclair; A. Charles Zehnder, Newark; Henry B. Orton; Francis R. Haussling, Second Vice-President of the Medical Society of New Jersey; Charles McGinnis, D.D.S., President, The Associated Physicians of Montclair and Vicin-

ity; Guy Payne, Superintendent, Essex County Hospital, Overbrook.

Dr. James T. Hanan, of Montclair, was Toastmaster and outlined briefly Dr. Areson's career. He was graduated from The Columbia University College of Physicians and Surgeons in 1896. After an internship at St. Joseph's Hospital, Paterson, he started to practice in Upper Montclair. Very shortly he was made an Extern of Mountainside Hospital, the first doctor to hold this appointment. Soon after this he was made an Assistant Surgeon and in 1910 he was made a Full Attending Surgeon on the Staff and has served 2 terms as President of the Staff of Mountainside Hospital.

He is a Director of the First National Bank of Montclair and was one of the organizers of the Watchung Title & Mortgage Guaranty Company, of Montclair.

In 1917 he was among the first to volunteer his services in the World War. He was given high rank in the Navy and put in charge of one of the largest Naval Hospitals in this country. He was Chairman and leading spirit of The Montclair Veterans' War Memorial Committee.

For several years he was President of the Board of Health of Montclair and since the change in form of government in 1923 he has been Director of the Department of Health.

He was made Chairman of the Medical Advisory Committee of the Board of Freeholders of Essex County at the time of the reorganization of the Essex County Isolation Hospital. He is a Consulting Surgeon at the Essex County Hospital, in Overbrook, Essex Mountain Sanatorium and the Essex County Isolation Hospital.

For the past year he has been President of the Essex County Medical Society.

The Honorable Oscar L. Carlson, Mayor of Montclair, was then introduced. He said that due to Dr. Areson's foresight and untiring efforts, Montclair has one of the best Health Departments in the State and one of the finest milk codes in the country.

Dr. Victor B. Seidler, Vice-President, spoke for the Staff of Mountainside Hospital, due to the unavoidable absence of the President, Dr. F. Elmore Hubbard. He said that on the Staff of a hospital the men get to know each other well and Dr. Areson is an associate who always gives his best and is conspicuous for his diligence, fairness and generosity. His judgment is good and always honest. He has the ability to make people work together and it is a privilege to work with him.

The Honorable Ernest A. Reed, Supervisor of the Board of Chosen Freeholders, said that some people have the power of projecting themselves into the future. Dr. Areson has set certain things in motion, the benefit of which will be felt for many years. The high esteem in which the Isolation Hospital is held is due largely to Dr. Areson.

Dr. Frederic J. Quigley, of Union City, President of the New Jersey State Medical Society, announced that he had appointed Dr. Areson to the Welfare Committee of the State Society.

State Senator Joseph G. Wolber said that many people think of a doctor as a recluse and not interested in ordinary affairs. They are wrong. All doctors, besides practicing this profession, are constantly contributing to the protection of the health of the community. Dr. Areson has been conspicuous in his service to the community by his work for the County Hospitals and his aid and advice to the representatives in the Legislature, so that they might legislate soundly and constructively on matters of public health.

Dr. Levi W. Halsey presented to Dr. Areson an illuminated scroll, signed by all those present, as a memento of the occasion.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The stated meeting of the Academy of Medicine of Northern New Jersey, held on April 20, was under the auspices of the Section on Obstetrics and Gynecology. Dr. Louis E. Phaneuf, of Boston, Professor of Gynecology, Tufts Medical College, gave a very interesting discourse on "The Low or Cervical Cesarean Section; Technic and End-Results of 515 Personally Performed Operations". The paper was discussed by Drs. Condon, Bunting, Bingham and Mount.

The following Officers were elected: Arthur W. Bingham, President; Max Danzis, Vice-President; Recording Secretary, Adrian Ralph Kristeller; Treasurer, Henry C. Barkhorn; Corresponding Secretary, Harvey T. Herrold; Committee on Admissions, Donald C. Miner; Committee on Library, Frederick Alling; Trustees: Wells P. Eagleton and Edward J. Ill.

MONMOUTH COUNTY

Robert A. MacKenzie, M.D., Reporter

The May meeting of the Monmouth County Medical Society was held at the Fitkin Memorial Hospital, Neptune, New Jersey, on Wednesday evening, May 24. Dr. Robert E. Watkins presided and approximately 45 members were in attendance. After a short business session Dr. Watkins introduced Dr. Harold W. Jones, Associate Professor of Medicine, Jefferson Medical College, Philadelphia. Dr. Jones talked informally for an hour on the subject, "Medical Problems in Diagnosis", illustrating his points with case records of unusual interest. He opened his remarks with a tribute to the late Dr. Da Costa, whom he considered not only an outstanding clinician and diagnostician but a man of admirable character and gracious personality. Dr. Jones then mentioned the changes in diagnostic measures which have come about in recent years with the physicians' growing dependence upon laboratory tests. He emphasized the importance of careful coördination of clinical findings with laboratory data and the necessity for expert interpretation of the latter. He then discussed albuminuria and particularly the differential diagnosis of the so-called Epstein's nephrosis sometimes known as lipoid nephrosis. In Dr. Jones' opinion this condition is not a disease entity but a phase of subacute glomerular or parenchymatous nephritis in which, unlike the usual nephritis, no cause is apparent. The absence of blood in the urine is important in differentiating this condition as is also the markedly increased blood cholesterol and low blood protein. A large amount of water retention with anasarca, hydrothorax, etc., frequently distinguishes the clinical picture of lipoid nephrosis and fails to yield to ordinary methods of treatment. A remarkable increase in urine output and improvement in symptoms may be expected as a result of the present usage of high protein diet in these cases.

Differential diagnosis of jaundice is greatly aided by a profusion of laboratory tests including leukocyte count, blood cholesterol determination, van den Bergh reaction, blood clotting and bleeding time, fragility test of red blood corpuscles, and

reticulocyte count. Dr. Jones presented 2 cases with the same clinical picture and clinical diagnosis of cholelithiasis with common duct obstruction. Work-up of these patients revealed that both had gallstones but only 1 had obstructive jaundice. The other case had acute hemolytic jaundice. Treatment of the latter case consisted in the removal of the spleen after pre-operative preparation by transfusions.

Recent studies in convulsive states were next considered. The word epilepsy is less frequently used than formerly because of the stigma associated with the name and because this condition is not a disease but rather an expression of a constitutional defect. Dr. Jones cited particularly the work of Dr. Johann, of New York, and Dr. Wilder Penfield, of Montreal. The case of a young man whose symptoms suggested petit mal was described at length by Dr. Jones as an illustration of a functional derangement referred to as narcolepsy in which hypersecretion of insulin appears to be responsible for the symptom complex. The patient described, a man of athletic habit and keen brain, habitually fell into a stupor or sleep each evening seeming unable to respond to pleasant diversions. He had frequently drowsed while driving his automobile and narrowly escaped injury. For some time past this man reacted unfavorably after exercise instead of experiencing benefit. Careful physical examination proved negative. The normal blood pressure helped to rule out Addison's disease. Renal function test, blood count, blood and spinal fluid Wassermann tests were all negative. The basal metabolic rate was —30. The most important diagnostic feature in this case was a glucose tolerance test. Blood sugar determination following ingestion of glucose showed practically no increase, giving a so-called "flat curve". In this patient the blood cholesterol finding was 300, an unusual and unexplained increase above the normal. Under treatment with thyroid extract and high carbohydrate diet this patient has improved somewhat and the basal metabolic rate is now +8. Some of these patients are resistant to treatment and surgical removal of a portion of the pancreas has been recommended.

Therapy in secondary anemia was touched upon briefly. With regard to iron therapy Dr. Jones made a plea for inexpensive remedies which he believes are quite as efficacious as the costly proprietary preparations. He recommends iron and ammonium citrate in doses up to 120 gr. per day or reduced iron 60 gr. a day. In differential diagnosis of the anemias careful study of stained smears is essential, of course, but cases of persistent anemia should always have gastric analysis to determine the presence of free hydrochloric acid. Where primary anemia does exist the use of intramuscular injections of liver extract is very effective in Dr. Jones' experience and he recommends this form of treatment not only where oral therapy fails but also as a treatment of choice since frequently one injection every 10 or 14 days will keep the patient well. Such a program involves not only lessened expense but also the minimum annoyance.

Among the blood dyscrasias no group of cases are more interesting or more difficult than those grouped under the name agranulocytic angina or pernicious leukopenia. The latter name is preferable because it is descriptive indicating that in this condition the blood stream contains many primitive granulocytes just as in pernicious anemia there is a preponderance of immature red blood corpuscles. Dr. Jones dwelled briefly upon the value of intramuscular injections of nucleotide, the use of which seems to encourage the ripening of the myeloblasts. An unpleasant reaction is to be expected, however. Leukocytic extract has also been devised and employed to some advantage in this condition.

Finally Dr. Jones introduced a patient who illustrated one of the most confusing and little understood blood disorders, purpura hemorrhagica. This man showed a very extensive ecchymotic area of 1 leg, the result of a trivial injury, and gave a history of many such bruises. To this time he has sustained no serious difficulty from his condition. "Bleeders" may be classified in 3 groups: (1) purpura hemorrhagica or thrombopenic purpura (occasionally hereditary), (2) hemophilia (practically always hereditary), (3) thrombo-asthenic purpura; the differentiation into these groups depending upon the number of characteristics of the blood platelets. Special tests of value in the study of these cases, in addition to the bleeding and clotting time, are the capillary resistance test, the venous bleeding time and the clot retraction. Lack of good clot retraction may be the only finding in thrombo-asthenic purpura. In the treatment of the uncontrolled bleeding Dr. Jones has used all the commercial products designed to favor clotting of blood without much success and places his chief reliance upon whole blood transfusions. He condemns the use of female sex hormone in hemophilia.

It is important to remember that there is a tendency to remissions in hemophilia. The form of treatment giving results in his experience is the use of high protein-high vitamin diet and sensitization of the individual with goat serum or chicken serum intramuscularly. He has found the use of fibrinogen intramuscularly of some benefit in diminishing the clotting time.

In purpura he employs anti-human platelet serum obtained from dogs to break down the platelets and so produce clotting.

In the discussion which followed much of interest was brought up and Dr. Jones endeavored to close his instructive discourse by brief answers to the questions asked. Dr. Altschul, of Long Branch, discussed the subject of "Functional Hyperinsulinism" and cited cases from his own experience and asked if Dr. Jones' experience had helped him to form any definite conclusions concerning this entity. He also asked Dr. Jones about the prognosis in recurrent malignant neutropenia and whether he had had any good results from x-ray therapy in these cases. To which Dr. Jones replied that the prognosis is uncertain but that he has had very good results with x-ray therapy. Dr. Albright, of Spring Lake, referred back to lipoid nephrosis and gave his opinion that such a clinical entity exists.

In answer to Dr. Nichols' question, on how the hemophiliac is sensitized, Dr. Jones answered that he first tests the individual with serum to find out if he is sensitive, then he gives 2 c.c. of serum and waits 2 weeks. If the individual is not yet sensitive, he repeats this injection and continues this plan until sensitization is accomplished. Dr. Nichols' next question was the differentiation between malignant neutropenia and aplastic anemia and also what the indications are for splenectomy in children. Dr. Jones answered that in aplastic anemia, anemia and bleeding from the mucous membranes are the rule. This is not so in neutropenia. There are usually no throat signs in aplastic anemia. The platelets are low in aplastic anemia and unaffected in neutropenia. Bone marrow puncture and examination show typical hypoplasia in aplastic anemia. Splenectomy is indicated in

some cases of purpura hemorrhagica, in sickle-cell anemia, Banti's disease, von Jaksch anemia and hemolytic jaundice.

Dr. Guillium, of Asbury Park, wished to know if there was any data on x-ray therapy to the pancreas in hypo-insulinism. Dr. Jones said that he knows of no such use of x-rays.

Finally, Dr. Brown, of Freehold, wanted to know whether Dr. Jones thought that copper plays a part in iron therapy. Dr. Jones does not think that it is of value.

The following members of the Monmouth County Medical Society attended the Annual Meeting of the American Congress of Physicians and Surgeons and Component Societies in Washington on May 8-10: Dr. C. A. Pons, of Asbury Park, attended the meetings on Bacteriology, Pathology, and Cancer Research; Dr. R. W. Baeseman, of Asbury Park, attended meetings of the American Ophthalmologic Society and the American Laryngologic Society; Dr. Joseph Wiener, of Asbury Park, attended the meetings of the American Gastro-Enterologic Society and the Association of American Physicians.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A regular quarterly meeting of the Morris County Medical Society was held the evening of Thursday, June 15, at the New Jersey State Hospital at Greystone Park, with President Pinckney presiding over an attendance of about 40 members.

Routine business included approval of various proceedings of the Executive Committee and of intervening special meetings of the society since the last regular meeting.

The Nominating Committee submitted its recommendation of officers for next year, to be voted upon at the annual meeting in September, as follows: President, Dr. Frost; Vice-President, Dr. McMahon; Secretary, Dr. Ward; Treasurer, Dr. Young; Reporter, Dr. Curry; Historian, Dr. Kice; additional members of the Executive Committee, Drs. Pinckney, Williams and Larson; member of House of Delegates for term expiring 1936, Dr. Costello; Alternate, Dr. Carberry; member of the Nominating Committee of the State Society for 1934, Dr. McMahon.

The Delegates submitted a report on the Annual Meeting of the State Society which was read by the Secretary; setting forth in detail a sketch of the proceedings and indicating a well arranged program. The exhibit of "hobbies" should be the beginning of a fine display, and altogether worthy of a better attendance of members. The Delegates received a vote of thanks for their comprehensive report.

Dr. L. W. Graddick, of Morristown, was duly elected to membership in the society.

Dr. Henry H. Ritter, of New York, Assistant Professor of Surgery at Columbia University Postgraduate Medical School, Visiting Surgeon to the Reconstruction Hospital, and Assistant Visiting Surgeon to the New York Postgraduate Hospital, was introduced by President Pinckney as a substitute for Dr. John J. Moorhead who was scheduled for the evening but was unable to be present. Dr. Ritter spoke extemporaneously upon the subject, "Some Principles of Traumatic Surgery". He classed traumatic surgery as a definite specialty and something that has been in the making a good many years without being properly recognized. First comes treatment of the person, and second treatment of the injury, if sad results are to be avoided; every injured person suffers from shock of injury; before any attempt is made at diagnosis, the patient is placed in bed in shock position; treatment includes external warmth by lamps, lights or hot water bottles, and morphine for relief of pain, the Murphy drip, and blood transfusion, which should not be given so fast as to overburden the heart. Traumatic surgery is emergency surgery and cannot be postponed. The technic of immediate reduction includes avoidance of contracture—the correction of which would require another operation—by putting on traction at once. To avoid the danger of infection, every injury should be regarded as an infection until it proves itself otherwise. The most efficient antiseptic is clean water and soap, and tincture of iodine; while, to carry away the wax, either benzine, kerosine or gasoline is valuable. The wound should not be sutured immediately unless it is very large; a delay of 24 hours is advisable. The speaker expressed preference for full thickness in skin grafts, and stressed a lessening of alarm in skull fractures, because no one ever died or would die of skull fracture unless it was associated with intracranial damages.

Discussion was entered into by Drs. Costello, Thomas, Rubin, Collins, Frost and Haven, and the questions raised were readily answered by the speaker, with appreciation of their being asked.

Adjournment was taken to the hospital cafeteria, where refreshments were served.

SOMERSET COUNTY

J. L. Young, M.D., Secretary

The regular monthly meeting of the Somerset County Medical Society was held at the Nurses' Home of the Somerset Hospital on June 15, with President Thomas Flynn in the Chair and the following members present: Drs. Ely, Lawton, Renner, Pigott, Maurice Borow, Stillwell, Hegeman, McConaughy, Flynn, Barbour, Halstead, Sferra, Baker, Smalley, Meigh, Young, and Lovejoy.

The Board of Censors reported a new applicant, Dr. W. J. Albrecht, of Somerville, and recommended his admission to the Society.

A letter was read by the Secretary from Dr. Cosgrove, of Jersey City. This letter suggested that we amend our Constitution to provide for a permanent Committee on Post-Graduate Medical Education. This was followed by discussion and it was ruled that this be not done, but, later, there was appointed a Committee on Post-Graduate Medical Education, as follows: Drs. Renner, Chairman; Brittain and Young.

Dr. Meigh spoke about the meeting of the Pre-Natal Welfare Commission at Atlantic City.

There was an open discussion of Senate Bill No. 226, which pertains to osteopathy. This Bill was discussed in detail by Drs. Ely, Lawton and Meigh. Dr. Lawton submitted a resolution as follows:

"Whereas, the practicing osteopaths accepted the Limited Practice Act in the State of New Jersey; and

Whereas, the present Senate Bill now in committee and known as Senate Bill 226 privileges the osteopaths to prescribe medicaments and to do minor surgery; and,

Whereas, it has continuously been the policy of the American Medical Association and the Medical Society of New Jersey to uphold and protect the standards and ethics of medical practice laws in the country; therefore,

Be It Resolved, that the Somerset County Medical Society, a component unit of the State Medical

Society, desires to go on record as opposing Senate Bill No. 226 in its present form now pending in committee."

This resolution was unanimously approved by the Society, and the Secretary was instructed to so inform our Senator, Hon. Dryden Kuser.

The regular meeting adjourned, and the speaker, Mr. Harry C. White, of Bound Brook, spoke of electricity and demonstrated some of its unusual phenomena. This lecture was also attended by the Woman's Auxiliary, Administrative Staff of the Hospital, and student nurses.

Refreshments were served and the general meeting adjourned.

Obituaries

SCHAUFFLER, William Gray, 21 Morven Place, Princeton, New Jersey, died at his home on April 30, 1933, at the age of 71 years. He had been for several years engaged in a losing battle with a cardiac affection, and he fought nobly until a stroke of apoplexy terminated the struggle.

Dr. Schauffler was active until 4 days before his death. The day before he was tricken he had introduced Mrs. Ethel C. Taneyhill, Field Secretary of the New Jersey State Medical Society, at an assembly of the Junior High School, and had later attended the Wednesday luncheon of the Nassau Club.

Dr. Schauffler was born of missionary parents in Constantinople, Turkey, on October 28, 1862, a son of the Rev. Dr. Henry Albert Schauffler. He received his A. B. from Amherst College in 1886, and in 1904 the same institution awarded him the degree of Master of Arts for his original investigation of the staining of the Klebs-Loeffler bacillus. In 1889 he was graduated from the College of Physicians and Surgeons, Columbia University, with the degree of Doctor of Medicine (M.D.).

In 1891 Dr. Schauffler married Miss Eleanor H. Hawkes, of Springfield, Massachusetts, who died in Constantinople less than a year after her marriage, leaving a son, William Gray Schauffler, Jr. In 1894, Dr. Schauffler married Miss Lilian Miner Boswell, of Hartford, Connecticut. In addition to his widow and his son, now Lieutenant-Colonel Schauffler, of Miami, Florida, Dr. Schauffler is survived by an adopted daughter, 2 grandchildren, and 8 brothers and sisters. One of the brothers is Robert Haven Schauffler, the author.

From 1891 to 1896 Dr. Schauffler was a Professor in the Medical Department of the American University at Beirut, Syria, and thereafter until the United States entered the World War, he was engaged in general practice in Lakewood and Spring Lake, N. J.

After serving for months in the Army during the World War, Dr. Schauffler settled in Princeton where, since 1920, he had been medical adviser to the Princeton Theological Seminary. His Summers were spent in research, in Woods Hole, Mass., in the Marine Biological Laboratory. He was President of the New Jersey Sanitary Association while living in Lakewood and for 7½ years a member of the New Jersey State Board of Education, serving for 4 years as President of the Board. In 1917 he was President of the Medical Society of New Jersey.

Military affairs always attracted Dr. Schauffler. In 1905 he became a member of the New Jersey National Guard. He was Lieutenant Colonel of the Medical Corps and Surgeon-General of New Jersey, 1911 and 1917, and was Aide de Camp to 3 Governors of his State. He was Lieutenant Colonel, Sanitary Inspector, 39th Division, at Camp Beauregard, Louisiana, and in France, and later attained the rank of Colonel, Medical Corps, United States Army. In Germany, in the early post-war period, he served as Information Officer for the Advance General Headquarters and was attached to the High Rhineland Commission.

He was Past Master of the Lakewood, 174, Lodge, F. and A. M., demitting to the Princeton Lodge, and he was Grand Marshal of the Grand Lodge in 1912. Dr. Schauffler belonged to the Jersey City Consistory, the Goodwin Chapter at Manasquan, N. J.; the Commandery at Asbury Park, N. J., and the Salaam Shrine at Newark.



WILLIAM GRAY SCHAUFFLER

He belonged also to the Society of Colonial Wars, the Sons of the Revolution, the Society of the War of 1812, the American Legion, Psi Upsilon and Phi Beta Kappa. His clubs were the University, the Amherst of New York and the Nassau of Princeton. His politics were Republican. He was a ruling elder of the Presbyterian Church and a former Commissioner to the General Assembly.

Funeral services were held on Wednesday afternoon in the First Presbyterian Church, being conducted by the Reverend Charles R. Erdman, D.D., L.L.D., Pastor of the Church, assisted by the Reverend J. Ross Stevenson, D.D., L.L.D., President of Princeton Theological Seminary, and the Reverend Wilhelmus B. Bryan, Director of the Westminster Foundation.

The musical service was led by a group of the Westminster Choir, under the direction of Mr.

David Hugh Jones. Dr. Schauffler's favorite hymn, Addison's Hymn to the Creation, was sung by the choir.

No Sorrow

There is no sorrow with the dead,
Grief stays here with us on earth.
If past the grave a word be said,
It is a word of mirth.

A word of grace, a word of hope
For us who, too, one day must follow
When trumpets blare—out through the glen
And drums beat in the hollow.

We, too, shall climb the mountain, Death,
And bearing down the farther slope,
One with Eternity's vast breadth,
Fling back a word of hope.

A happy word to those who stay
Within the glen or in the hollow,
To tell them of our joyous way,
To wish that they might follow.

(Gertrude Callaghan.)

SHERRON, Clifford M., dean of the medical profession in Salem County, died on Sunday, June 18, at his home on West Broadway, Salem, at the age of 77 years.

Dr. Sherron was the son of the late Albert W. Sherron and was the last in that family line who have been residents of Salem County for so many years. He is survived by his widow, Harriet Sinnickson, a daughter of the late J. Howard and Elizabeth Forman Sinnickson, whom he married in 1885. They had one son, Clifford, who died in boyhood.

Dr. Sherron long held a prominent place in the professional and civic life of Salem. After receiving an early schooling here, he entered Lafayette College and was graduated from that institution. He then entered the Medical School of the University of Pennsylvania from which he received his degree as a Doctor of Medicine.

He began the practice of his profession in Salem in May, 1879, at first in the Morris Building, now occupied by Newkirk's store on West Broadway, and later, and until his death, at his own residence at West Broadway and Chestnut Street.

Always interested in the financial affairs in Salem, he was a large stockholder in the City National Bank and Trust Company, as well as the Salem National Bank and Trust Company. He devoted most of his time to the affairs of the City Bank, and in 1929 was elected President of that institution to succeed the late Biddle Hiles. Upon his retirement from that office he was made Chairman of the Board of Directors, of which body he had been a member for 30 years.

When the Salem Country Club was projected in 1898, he, with a small group of men, was most active in its establishment. He served on the Board of Governors of that Club from its beginning in 1898 until 1913 when he was elected President, filling that office until 1927, when he declined further reëlection.

He was the oldest member of the Salem County Medical Society and at one time served as President of that body. With the passing of Dr. Sherron, Dr. Albert T. Beckett is the oldest physician now practicing in Salem.

At the time of the planning of the Salem County Memorial Hospital, Dr. Sherron took a foremost part. He served as President of the Medical and Surgical Staff from the organization of that body in 1919 until his death. He maintained a constant interest in the work of the Hospital, and was a liberal contributor to that institution.

Dr. Sherron took a lively interest in any movement having for its object service to others, and when the Salem County Chapter, American Red Cross, was organized he was one of the men who made it possible. He was honored with the Chairmanship of the Chapter and reëlected each year. He was the Chairman at the time of his death.

He served as a member of the Executive Committee of the Salem County Mutual Fire Insurance Company for a great many years. He was one of the founders of Woodmere Camp; and a member and President of the Fenwick Club, the latter social organization being started here more than 75 years ago.

Dr. Sherron was a life-long member of the First Presbyterian Church and at the time of his death was President of the Board of Trustees.

Services were conducted by Rev. Alison R. Bryan, Pastor of the First Presbyterian Church, assisted by Rev. Thomas V. Wingate, of St. John's Episcopal Church.

Interment was made in the Sherron plot in the Presbyterian Cemetery.

The honorary pallbearers were: Loren P. Plummer, Bernard A. Hilliard, William H. Hazelton, William H. Chew, Dr. John Summerill, Dr. William H. James, Dr. R. M. A. Davis, Dr. David W. Green, J. Dale Dilworth, D. Stewart Craven, C. Preston Casper, Dr. Warren L. Ewen, F. Newlin Acton, Charles H. Ayars.

It will be difficult to replace in Salem a man like Dr. Sherron. All his life having been spent here, practically all his interests were in Salem County. A large landholder, as well as the owner of numerous properties throughout the city, he was uniformly generous and considerate to his tenants. Few will ever know how many of those in distress he has helped; for even in the practice of his profession he carried this principle into effect. His professional charges to the unfortunate were practically nothing, and in many cases actually nothing. An old colored man recently told the writer that "Mr. Sherron—he always called him 'mister'—certainly does give you a lot of good medicine for a quarter".

In later years his practice was exclusively confined to his office but in earlier days his service as a physician had taken him into practically every home in town; and a large number of those who are feeling his loss most keenly today were at one time or another his patients. His cheery disposition and kindly manner endeared him to them all.

Whenever a worth-while civic movement was started in Salem during the adult life of Dr. Sherron he was called into it and he became an active and interested worker in practically every worthy cause. His home life was ideal and those who would often gather there to enjoy his hospitality and good fellowship will ever hold his friendliness in high regard. Personally, he was a delightful companion, whose sense of humor was so keen that he was the life of many a gathering.

Dr. Sherron had a long and useful life in Salem and his memory will be slow to fade in those who knew him best.

The sympathy of the entire community goes out to the devoted wife in these hours of her bereavement.

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THE SALT OF THE WORLD

(New York Times, June 20)

As President Lowell defined the salt of the world, they are those who do not lose their heads in times of public distress or excitement, who hold on to themselves * * * who keep their calmness and balance of mind, striving to see things in their true proportions, undisturbed by prepossessions, and on the other hand by fear, by hallucinations or the outcries of the impulsive multitude.

These words were addressed to his last graduating class at Harvard, but they might be heard to advantage throughout America and the world at this moment when all the savor of such saltness is needed to keep life sound and wholesome.

Among the essentials in society is personal character—supporting a standard of conduct beyond mere enforcement of law. The qualities of which it gives evidence in man are the enduring things, and to them we must turn in times of crisis, which means that they must be there at all times. President Lowell has been saying this in his own living for all these years as man, as teacher, as President. And it is to be hoped that now that he lays aside the routine responsibilities of office, he may have more freedom to give advice in public affairs. He should be especially helpful in enabling others to distinguish between the lasting and the temporary in our political, economic and social order, between "the things essential to the framework of every good human society and the expedients useful for the moment, not letting these impair the permanent structure."

The world needs the salt of such wisdom. The sum of Dr. Lowell's advice is to "hold fast to yourselves". In one of the Gospels it is written: "Have salt in yourselves and be at peace one with another."

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Lodger—"Madam, this morning when I bathed I found only a nail-brush in the bathroom. I can't wash my back with a nail-brush."

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Lodger—"Yes. but I'm no swan."—The Weekly Telegraph (London).

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IMMUNIZING FOR HEALTH

(Newark Evening News, June 16)

Medical science is advancing so rapidly the mere layman finds more to marvel at than he can comprehend. As for instance, the non-specific protein therapy, subject of an address at the Convention in Milwaukee of the American Medical Association. Injections of substances having no connection with the disease for which treatment is given is a bit beyond the mental grasp of the uninformed, but it is explained quite simply.

This is the beginning of a new era in dealing with sickness, it was declared by Dr. Clyde Brooks, of New Orleans, who prophesied that soon the physician will work for the immunizing of patients rather than the cure of specific illnesses after they

Continued on Page XXI

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The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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Continued from Page XVIII.

have developed. Thus the injection of proteins and other substances which, though not remedies for sickness, stimulate the body to combat disease without medical help. As it well known now, it is the bodily functions, the constitution, as it is sometimes called, which in the end dissipates illness, aided by the doctor's medicine and advice, which may be as to diet, exercise or other measures known to the healing art. Directly exciting these functions so the body will resist or expel disease with its own weapons, as it was expressed, is the method by which, it was predicted, the physician of the future will be an immunizer rather than a worker of cures through medicine.

There has been a steady approach to a goal such as this, a little observation of recent trends would seem to show. The convention speaker said medicine is passing beyond the idea of treating each disease with a specific remedy for that disease. All of which seems eminently sensible in principle and promising of a healthier, happier human race.

THROMBOSIS DEATHS GAIN

(New York Times, June 11)

Interest that has been aroused in coronary thrombosis since the recent deaths of former President Coolidge and Senator Walsh—the cause of death in each instance being diagnosed as due to this condition, which is a fixed clot of the coronary artery—has led to a study of thrombosis among the millions of policy-holders of the Metropolitan Life Insurance Company. This study, says an announcement from the company, shows that among industrial policy-holders thrombosis increased from 4.7 per 100,000 in 1930 to 7.0 in 1931, and reached 9.4 in 1932, a rise of 100% in 2 years. Among ordinary policy-holders the rates were 11.1 per 100,000 in 1930, 14.0 in 1931 and 17.1 in 1932.

The study reveals that deaths from thrombosis are increasing at an alarming rate both among the wage-earning and salaried classes. It is also noted that more than two-thirds of these deaths affect persons 60 years of age or older. As there is a larger number of those in the higher-age brackets insured in the Metropolitan's ordinary department, this accounts for the greater crude death rate in this department when compared with industrial.

The insurance company's statisticians point out that the importance of coronary thrombosis—as a cause of death—has only recently been recognized by vital statisticians throughout the world. At an international conference of these statisticians held in Paris 4 years ago they made provision, for the first time, for a separate accounting of deaths from this disease.

FOR INTERNATIONAL NURSES

(New York Times, June 9)

The British Red Cross Society has undertaken to provide a scholarship of $1,250 to assist in establishing the International Florence Nightingale Foundation, writes the London correspondent of The Journal of the American Medical Association. Three similar scholarships will be financed by the National Council of Nurses in Great Britain, the Nightingale Fellowship at St. Thomas's Hospital, the London Hospital Nurses' League, Guy's Hospital Nurses' League and King's College Hospital Nurses' League. The object is to establish on a permanent basis international post-graduate courses for nurses. It is hoped that a national Florence Nightingale Committee will in due course be set up in every country in which the Red Cross operates to raise funds for the endowment scheme. The League of Red Cross Societies, with headquarters in Paris, has made provision for 5 scholarships to be awarded to Red Cross nurses on the recommendation of their national Red Cross Societies, and a half scholarship has been promised by the Red Cross Society of Czechoslovakia.

Dr. and Mrs. Max A. Maas, of 329 Clinton Avenue, Newark, sailed on July 4 on the Holland-American liner the S. S. Volendam on an all-Europe cruise. Their itinerary includes the following countries: Madeira, Spain, Algeria, Italy, The Riviera, Belgium, Holland, Scotland, Norway, Sweden, Denmark, France, England. Dr. Maas plans to make several airplane trips into Germany to visit relatives. They will be gone 2 months.

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OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 8 Orange, N. J., August, 1933 Subscription, $3.00 Per Year Single Copies, 30 Cents

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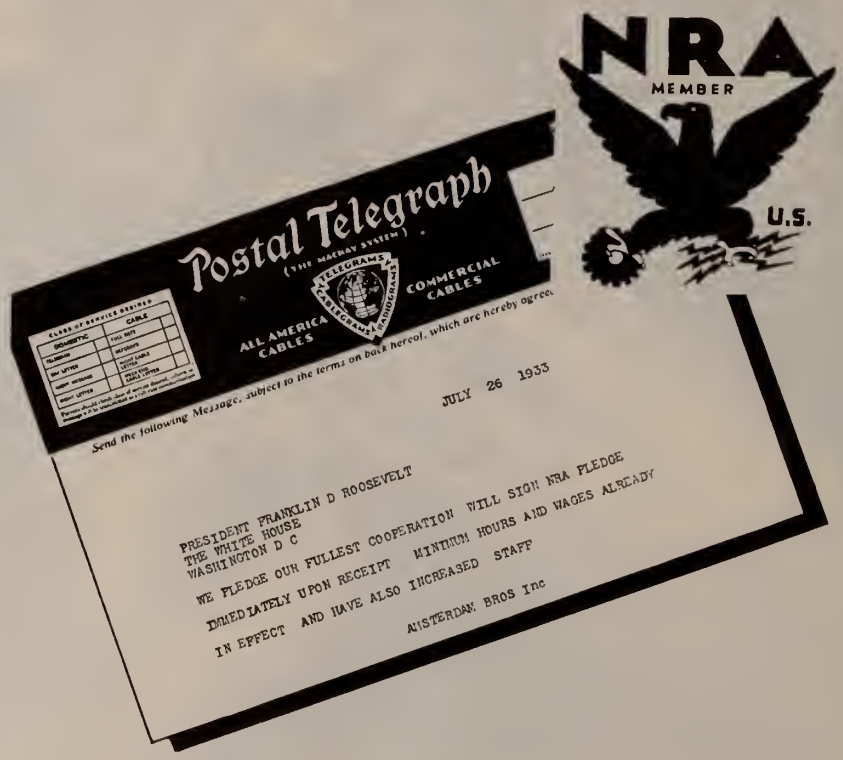
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(New York Times, June 13)

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The contest is open to high school students in the United States and its possessions and the cash prizes, which are donated by Henry L. Doherty, range from $10 for the State champions to $500 for the first prize and the national championship.

Winners of the State prizes in the New York area were Eileen C. Parmelee, of Waterbury, Conn.; Irene Carman, of Kearny, N. J., and Hope Hollinshead, of Yonkers.

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Vol. XXX., No. 8 ORANGE, N. J., AUGUST, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

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SYMPOSIUM ON MEDICAL ECONOMICS

Especially Prepared for an Evening of Entertainment and Instruction During the 167th Annual Meeting of the Medical Society of New Jersey Comprising 2 Articles

I.

ECONOMIC RELATIONS OF MEDICINE

William H. Ross, M.D.,

Ex-President of the New York State Medical Society,

Brentwood, Long Island, N. Y.

I am delighted to be your guest and to be invited to discuss the economic relations of medicine as well as to have the opportunity of listening to what others may say of what is probably the uppermost subject at present in the thought of most working physicians.

Though I approach a discussion of medical economics now-a-days with hesitancy, it once seemed a simple subject. To thoughtful men it has become a complex subject. It is difficult to discuss medical economics apart from the social influences of the general economic situation because it involves the efforts of government to improve the financial condition of people.

I have always been a private practitioner of medicine with an active interest in its public aspects. The more I hear other men discuss the problems of medical service, and the medical care for all classes of people and how to pay for it, the more confusing it seems; and yet, the fact stands out that all the discussion which is going on as the result of various "studies" indicates that there must be a need. During the past 10 years I have had an opportunity to observe the reaction of physicians to proposals for public medical service, the application of new State health and welfare laws, and the methods of delivering medical service to the indigent and to those unable to pay for it without financial hardship, while I was serving the New York State Medical Society, with its 14,000 members, as Vice-President, then 3 years as a Trustee, as President-Elect, President, and, for the past 3 years, as Secretary of its Committee on Public Relations. During that time of personal education, I have discovered some personal limitations and among them is the subject of *medical economics*.

Medical economics really means money, credit, prices, and such things as the law of supply and demand. The public relations of medicine, or the economic relations of medicine, are better terms. However, nothing attracts attention today more readily than economics. The burst of discussion everywhere includes medicine because medicine is closer to human problems than other services. The whirl of theory on how to correct the economic depression in commerce and industry, and the efforts of government to get the world out of the grip of post-war forces, influence, of course, payment for medical service. When the exciting swirl of economic speculation and theory subsides, and we are again "in the

middle of the stream", I believe that we will solve the details of the problems of medical care for all classes and that the services of medicine will remain the greatest social factor and will influence civilization just as it always has done. Medicine's problem is to correct defects in its services so that they will meet present day needs, and to make necessary adjustments in relationships to bring this about.

The relation of physicians to people paying for medical service on a fee basis presents no problem and we have only to deal with the problem of the care of the indigent and the large group of people at present near to the relief class upon whom the costs of medical care impose a too heavy burden. These 2 things, and the relation of physicians to the public aspects of medicine, make up the situation confronting organized medicine.

If we accept the information included in the data assembled as constituting a problem in application of the services of medicine, then we must work out what we believe to be a sound program for meeting it. We should not be disturbed by the grasping at half-truths of enthusiasts who would establish untried plans in place of the experience of centuries, instead of correcting defects as they are discovered and incorporating changes to meet new needs as social evolution goes on. This implies open-mindedness on the part of the profession.

Dr. Rexwall Brown, of California, says that medical economics does not usually exist to any extent other than in an individual physician's money relation to an individual patient as payment for service.

The position of medicine in public opinion will depend upon what it does to meet new conditions and not on how much it objects to situations brought into the open by various studies and investigations. The profession of medicine has the matter in its own hands, since it is the only authoritative source of medical knowledge, and it will not allow the situation to go by default nor permit unsound programs to become established. I am sure, from personal observation, that the profession of medicine, as a whole, is emerging from its state of lethargy and is moving toward consideration of the public aspects of medicine, and I believe that it will not be long before its active leadership will be recognized even by the sociologists. I do not believe that there is any serious danger of public failure to see that physicians are, after all, the principal agents in any medical project.

Social Conditions

Let us keep in mind the intimate relation of medicine to social conditions and for a moment review the changed attitude of the public, and the changed attitude of government, toward social needs, and not lose sight of the fact that medicine is subject to public opinion even more than are other services.

The economic situation of the physician is a part of the socio-economic state of the world. The social function of medicine is more closely than ever before related to the social state of the people. The relations of medicine have come into bold relief in very recent years because of the health consciousness of the people and the changed attitude of society toward its responsibility for medical service and medical care for people who cannot obtain it from their own resources.

Medicine has become more complex. It has advanced further in the past 50 years than in all the previous centuries; but technical application is expensive and it is unlikely that its professional delivery can ever be at a lower cost. Because of these things and the fact that medicine is a vital necessity, it is confronted more than any other service with a demand for a full distribution of its knowledge. It is the obligation of medicine to set up a plan without defect in order to escape, if possible, such undesirable conditions as exist in other countries.

Today our nation is departing from the social order of unplanned, slow, and unconscious growth. From colonial times until about the end of the nineteenth century there was a refuge in this country from economic distress in the opportunities of the frontier. The economic conditions in England caused the immigration to America 300 years ago. The lure was free land for almost everyone and an opportunity to be heard in the affairs of government. It marked the greatest advance for the common man in a thousand years.

(James Truslow Adams.) All through our history there runs the opportunity of the frontier—always an escape into new fields—until no more than about 30 years ago. Since that time, with the exception of the period of the World War and its following social and economic influences, we have been getting ready for what we have today.

The conservatism of medicine, desirable as it is in almost all of its relationships, has nevertheless kept the profession from fully grasping the tremendous effect of what is going on in our national affairs and in the world, and their effect upon the services of the most vital necessity in the world. We have not fully sensed the almost invisible and almost intangible influence of changed conditions. I do not know of any other explanation of the first reaction of the medical profession to the Report on the Costs of Medical Care. One of the best and most thoughtful of my medical friends still characterizes the report as of "library interest". We have hardly known where we were going or how fast we have been getting there. Newton Baker, at Amherst quite recently, said "America is in the League of Nations and the United States Senate does not know it". Medicine is faced by a great problem and the mass of us do not seem to know it.

Just now, as there is a possible beginning struggle between individualism and collectivism in government, so there may be something like it in medicine. We have the beginning of governmental partnership in industry. We have controlled currency, controlled prices, controlled production. We have a strengthened banking structure with weak units eliminated at one stroke. We have drastic economies in government, on one hand, and enormous bond issues, on the other, in order to put 25,000,000 unemployed men at work, and increased taxation to pay fixed charges and amortization. We have work relief in New York State which cost $2,500,000 in 1931, $70,000,000 in 1932, and $100,000,000 in 1933. We do not call the present trend of our national policy socialistic even though government is nearly in control of industry, of money and wages, and may soon control working hours. (The latter is not a new thought, however, for Benjamin Franklin proposed a 30-hour week 175 years ago.) The planned industry or governmental partnership that we hear so much about was demanded 20 years ago. It was advocated by Theodore Roosevelt and now by industry itself, organized labor and exponents of social reform. If the present day efforts to lift the economic depression become permanent, then where is the no man's land between individualism and government? The same reasoning applies between the principles of the delivery of medical service and government but even if this is so, the regulation of details which organized medicine can plan for, if it will, may not be as undesirable as feared. To any student of the trends in government today it should be plain how rapidly as a nation we are changing. We think it applies only to business and industry but if it comes to apply to services, medicine will be the first.

If controlled production, artificial increase of prices, federal work loans, new mortgage credit, financing of home mortgages, and guaranteed bank deposits, are desirable paternalistic activities and approved social evolutions, is not "the delivery of adequate scientific medical service to all the people at a cost which can reasonably be met by them in their respective stations in life" a reasonable objective for medicine to plan for, aided by health agencies, hospitals, and foundations, and then, one more step—to work out a method by which the physician may be paid for his time and his skill and give him an opportunity to earn a decent living?

Most of the medical discussion has apparently approached the problem of the economic relations of medicine without fully realizing how far our nation has gone in its social evolution. Just recall every-day things such as the dramatic change in the picture of American transportation, with its freight and passenger traffic diminished 50% in a decade, the development of the automobile and the building of roads, airplane travel, and our use of the radio. Then, those of us who were raised on the *gold standard,* believing it to be the foundation of economic stability, have just found that economic conditions are improved by its absence. The barriers of nations are

breaking down and whatever any nation does affects the life and welfare of all other nations.

While we are all talking about medical care, do we realize that this country is going through a social revolution and that we have confidence in it? Apparently, the public has lost its fear of experiment in government. Social control over industry seems inevitable, and *social control of medical services may be the next step if the organized profession persists in its stand-pat position,* instead of undertaking leadership in the formulation of plans to provide medical care for those who have not means enough to pay for it, and taking the initiative in proposing a way for paying the physician for his labor.

The efforts of organized medicine to adjust its economic relations in medical care differ from the efforts of government to get us out of the grip of post-war influences, only in the fact that a majority of those constituting the organized profession stands in opposition to the formulation of constructive plans to meet this situation of paying the physician for his skill and labor; while government today is being supported by a nearly unanimous public opinion and is unafraid of new methods to meet present conditions. As physicians we discuss the economics of medicine from our own point of view almost exclusively and let the public discuss medical care from its viewpoint, instead of a consultative effort about a situation of vital necessity to the public, on one hand, and the prevention of professional bankruptcy, on the other.

We have been characterized by many of our own number as being about 5 years late in deciding about any innovation, but the conservatism of medicine is, really, a public asset. It is true, however, that men argued about the justice of human slavery for 2000 years and abolished it less than 100 years ago. The book entitled "Other People's Money", by Justice Brandies, published 20 years ago, aroused little interest. It is now at the very core of any present-day discussion of economics.

The methods by which the human race dealt with crises in the past are not sufficient for the crisis of the present because for the first time in the history of America there are world-wide relationships and in this country the absence of the opportunity of the frontier. Economic activity in business has always been regulated by supply and demand operating through rising and falling prices. This *laissez-faire* has broken down into economic disorder and, notwithstanding all this, many physicians think that we should let matters drift. We must decide whether we will settle the crisis in medical care and near bankruptcy of physicians, or will let others do it. Medicine still has the confidence of the public; and if we can hold it through this crisis we will make our profession the supreme social influence in all the world. Medicine has never had such an opportunity to take leadership of all health agencies in the distribution of its services as it has in this crisis which is exactly comparable to the crisis in government apparently now passing.

The services of medicine must be distributed by methods under the control of the profession itself, and the profession must remain "master in its own house". We cannot meet the great problems confronting the profession by methods in line with time-worn traditions of medicine, any more than the general economic state can be cured by methods in line with the time-worn traditions of bankers. A *new era* may not be developing in medical care but the attitude of society will prevent a return to former conditions when this economic depression passes.

We stand today at the cross-roads, with an increasing degree of open-mindedness as to which we should take (and I think that this statement may include the Editor of the A. M. A. Journal), faced with necessary adjustments to meet certain problems in medical service and payment of physicians for their work for an increasing number of people. We have never before had a situation just like it. Social conditions have become different. Medicine is not being criticized by public opinion; it is just being asked to do certain things, and being given a chance to do them.

That a portion of the people cannot pay for medical care is not due to any inherent defect in the private practice of medicine but to factors which have come into our national life,

such as disturbances which lead to unemployment, limitations on circulation of currency, over-elaborate hospital building and resulting overhead costs that must be met somehow. The public has awakened to the costs of medical care. It has passed beyond placing the responsibility on the physician but it is looking to him for a plan to solve the problem. Medicine may be approaching a new phase in its existence.

The Medical Situation

The Wilbur Committee, the Lowell Commission, the Commission on Social Trends, Studies of Health Insurance, and the vast medical literature, should be thought of as information, and the recommendations as tentative. There have been hasty statements made in discussion, on both sides; and perhaps regretted by this time. It cost the medical profession in England $150,000 to establish an acceptable relationship to its National Health Insurance Act, because it did not act in time. It cost our profession in France 1,000,000 francs to establish a desired relationship to the French system of Health Insurance, because it did not consider the facts of the sickness problem and take leadership in their solution at the proper time.

There is no possible advantage in denying the conditions inherent in the society with which we live; certain facts of medical practice, such as the disappearance of some diseases; the over-crowding of the profession, by continuing to admit 5000 newly graduated physicians each year—while 20% of practicing physicians had deficits in 1932; with the incomes of 80-90% of the people only a little above providing the bare necessities of life; the unpredictable expense of sickness and "its frequent financial tragedy"; and, the difficulty of delivering the services of modern medicine except as the profession's gift (of free or nearly free service), aside from the indigent for whom we all agree that the responsibility belongs to the community and should be paid for by general taxation.

Medicine has a *product* that the world needs, and a part of the world cannot get it, or cannot get enough of it, because it cannot pay for its purchase. Will a provision for this condition be made in the near future, whether we like it or not? Will it carry along with it compensation for the doctor? It would seem that *now is our opportunity* to say what we think should be done about it. Public opinion will meet the situation, if we do not lead in its solution. Already, medical service is in the beginning of a transitional stage, through the *expansion of welfare service*. It would be very nice to think that, as soon as the economic débacle lifts, we will go back to such opportunities as those of the frontier and of prewar days.

We hear much talk about the evils of clinics and the efforts of people to get medical service for nothing. I was an intern in the Presbyterian Hospital in New York 45 years ago, and talk of the abuses of the Out-Patient Department by people who should have paid a physician, was just as common then as it is today.

Hardly any 2 counties in New York State sustain the same economic relation to the medical administration of public welfare. I am familiar with 1 county which has a population of about 200,000 and which pays to physicians for medical service $4000, and another county of 160,000 people which pays the local profession $40,000 for medical service.

Medicine needs as complete organization as it has in Denmark—open-mindedness, active leadership, collective thinking, and the expression of unanimous opinion. Bruce Barton said after reading the book—"War Debts and War Prosperity"—that he was struck by the pathetic ineffectualness of the poor little human mind in the face of the immense problems of the past 18 years. One may, indeed, well wonder how much one mind, acting individually, can accomplish toward a solution of the great problems which confront the medical profession and which have been developing for a longer period than 18 years.

We approve the acts of government today that touch the price we must pay for the food we eat, the clothes we wear, the wages we get, the money we spend, the taxes we pay, and the means of protecting our savings—if we have any. A bank can be told to close or to open, and with what degree of restriction, and what we can do with our gold; and this, with full

consent of us all. The wheat grower is to be told how much he may plant and to whom it may be sold; and others told why the production of cotton is regulated, and what one must pay for his clothes. There, is a change from the days of Andrew Jackson with their "equal opportunity", and their refuge of the frontier. *May not the services of medicine soon be regulated if we do not accept the facts and lead in the provision of a suitable remedy?* As well command the tides to turn as to stand only in opposition.

Before medicine can have any concerted action, it must decide what it wants to do—oppose, resist as long as it can, or coöperate in meeting the situation. Studies have been made by Sir Arthur Newsholme in several countries of Europe, concerning the relationship of the practicing physicians to public medical care and the public aspects of medicine. These studies throw some light on the problems in this country, also, which have come to the front with the present stage of social evolution. His studies are about the care of the indigent, provision for those of limited means, hospitalization, the expanding function of the State in caring for diseases that cannot be cared for or controlled in private practice, and methods of meeting the costs of medical care and medical service. I know that some of you have read those books.

Denmark is most interesting because it has quite well solved the problems that we are talking about, and it has kept the yearly income of physicians at 20,000 to 30,000 kroners, which translated means from $6500 to $10,000 a year, and about 66% of all the people in Denmark are *voluntarily insured*. The physician is trained by a 7-year course. The standards of qualification are high and uniform. The profession is well organized, and as an organization, it negotiates with the Insurance Companies as to payment for services, and fixes the rather liberal salaries of the hospital doctors. The practicing physician's interest in public health in Denmark is well known.

Denmark has an ample hospital system supported by taxation. Indigent patients receive free treatment, while others pay according to their means; any deficit is met by the government. The average income of physicians is a little more than $2500 a year from insured patients, and there is no restriction upon him as to private practice. There is a proportion of 1 doctor to 1400 people. In our country it is 1 to 780. The number of physicians qualified in Denmark each year bears a proper relation to the need, while we qualify 5000 a year without reference to the need. Finally, in Denmark, the "doctor" holds a high social position.

Position of Organized Medicine in New York State

The Medical Society of New York State, at its recent Annual Meeting, adopted unanimously the report of its own Special Committee on the Costs of Medical Care. The report said: (1) The cost of medical care is but one small feature of a large sociologic problem. (2) The quality of medical care depends upon the quality of the practitioner. (3) About 85% of the diseases or affections with which people suffer are complaints that present no difficulty in diagnosing and yield readily to treatment by the individual doctor in his private practice. (4) The worthy poor are properly the charge of the community, and the costs of medical treatment for them should be paid for from taxation funds. (5) The physician who treats them should be paid a *minimum fee* fixed by the community, for, to do otherwise "would be a social injustice because it imposes a double tax on the physician". (6) "Hospital care for the indigent in voluntary hospitals should be paid for from public funds." (7) "Hospitals rendering this service should not make a profit from it." (8) "To lessen the burden of hospital and nursing care for people below the comfort level, a plan of Hospital Insurance should be adopted." (9) "The Medical Society of the State of New York expresses itself strongly against any further extension of the Federal government in hospitalization and medical service to non-war incurred disability of veterans." (10) "Hospitals supported by public funds treating injured workmen in their charity wards should give the fees allowed by law to the physicians who serve this group of patients." (11) "The present method of treat-

ment of tuberculosis, insanity, mental defectives, and epilepsy, should be continued, and treatment of crippled children under direction of the State Department of Health should be continued, except that it is recommended that the State Department of Health should not become an agency for treatment of crippled children." (12) "The principles underlying the Detroit plan should be endorsed, for the purpose of distributing the burden of medical care and making preventive medicine an active issue for all practicing physicians." (13) Lastly, we endorse the following quotation from the Report of the Commission on Medical Education: "Allowing for the defects in present methods, there are fundamental advantages in the American form of practice. * * * It is not necessary to substitute for the present efforts a paternalistic plan, ill-adapted to the philosophy of American life but, rather, to encourage the evolution of a pattern that will embrace the desirable features of our present methods and the correction of their defects."

When you come to decide your problem, in your State, you will have to decide if this goes far enough to meet your situation.

Suffolk County Plan

I can best illustrate a plan for the working out of the problems of medical care and the economic relations of medicine by reviewing briefly what has been done by the Suffolk County Medical Society during the past 25 years. Its activities in the public aspects of medicine began at a time when the demands of the public in preventive medicine were less insistent and when medical care and medical service were not talked of so much as now-a-days. Its activities are a contribution to the study of the present economic problems of medicine. While there was no visualization of the future as it is now, its sense of responsibility caused it to make public contacts in medical needs and from this has developed medical leadership in all health activities in the County either by official or unofficial agencies. These activities have prevented abuses of medical service; public health organization has been advanced; the medical needs of the public have been met; free medical service has been limited to the indigent; a satisfactory professional economic condition has been maintained even to the present outside of the influence of the general economic situation; active consultative contact has been maintained with the welfare department as to its medical administration and the general intent of the law.

Looking over the past 25 years of the history of the Suffolk County Society and at the satisfactory relation of the local profession to every health and welfare activity in that County during that time, we find *indications that medicine has the solution of its problems in its own hands, simply by recognizing the fair demands of the people and planning to bring them about under the leadership of the profession.* The Suffolk County Medical Society assumed responsibility for local health problems in their early stages. The influence of its leadership has been in proportion to the completeness of its organization. From 1908 to the present time, its membership has been, by actual record, from 88% to 95% of all the physicians in the county, and of the active physicians from 95% to 97%. Professional organization was the first essential, for the purpose of collective thinking and the expression of unanimous opinion, and to this was added a constant effort to overcome professional lethargy and to bring the County Society into line with new currents of thought in medical relations. The new currents of thought at this time were just beginning to impress socially minded physicians that there was developing a new concept that medicine might have a larger purpose in service than had been thought.

The Anti-Tuberculosis Campaign and the building of a County Tuberculosis Sanatorium, in Suffolk County, were initiated by the County Medical Society 22 years ago. Leadership has remained within the profession and the result has been that while the public was having the service that it needed and morbidity and mortality were growing less, the physicians were having more work to do in tuberculosis. It took 5 years of professional activity in public education to establish a County Tuberculosis Hospital, but during the time the public and the county government were being

educated, the profession acquired considerable education also. The profession initiated the organization of a County Health Department in 1928 and has since directed its activities. Public health services have been multiplied many times and new ones established. For example, there is a Veterinary Division and the only bovine tuberculosis eradication program under the management of physicians in the United States. The cost of public health in Suffolk County in the last year of the old system with all of its inefficiency was $54,000 more than it is this year.

By giving leadership in the public aspects of medicine the County Society has increased the value of that service in many ways. One of them has been to increase the number of Public Health Nurses 15-fold. The County Society has supplied active leadership in every health organization in the County and in every health project, such as diphtheria control, cancer control, and venereal disease control. There are no "treatment clinics" held in the County, though more than 200 diagnostic and consultation clinics are held each year—1 every 4 days—each conducted by an expert, a member of the County Society and a resident of the County. Each physician is paid for his labor. The Health Department pays each and every physician for treating his own indigent venereal disease patients, on a fee basis.

When the welfare laws were enacted, in 1930, the County Society directed its active and experienced Committee on Economics to help the Welfare Commissioner, by conference in the medical administration of public welfare and to establish minimum fees for medical service, to have the service rendered by the family physicians just as in private practice, and to act as a committee of arbitration in disputed questions of service and payment of bills. With diplomacy, these ideals were established and have been carried successfully for 20 years. The County Society has been active in helping to standardize the hospitals of the County, and to organize the Medical Staff of each so as to give a controlled service with adoption of the principle that "every Staff Member must be a member of the County Society".

The County Society has, also, a Board of Arbitration, to act in disputed situations; as in compensation work, and the disputes between physicians and the carriers.

If there were time, I would make this part of the discussion complete, but there is not, at present.

In closing, may I say that if the experience of the medical profession in a local County Society has lifted its members into a position of leadership, simply by its activity in health problems and in giving the public the service that it wanted, and if at the same time professional welfare (just another term for medical economics) has steadily improved, and is satisfactory at the present time, with reservation only as to possible recent influence of national economics, then may not this bit of history be a constructive contribution toward solving the great problems now confronting the profession of medicine?

Traditional Ideals of Medical Service

Medicine was once a public service with its benefits distributed to everyone according to his need and paid for according to his ability. Out of this grew free service by physicians and the sliding scale of fees. These habits still characterize physicians to some degree. Current medical literature indicates that organized medicine is making an effort to fit these traditions into new socio-economic conditions and is having a hard time doing it. The effort is speeded up by new public ideals for medical service. It is a gigantic task to shift the former ideals of medical service into a new form in accord with modern conditions under which the physician must live. It is more difficult now because of the existing general financial depression and changed methods of government, which amount to the equivalent of social revolution in commerce, in industry, in banking, and even in providing employment.

The ablest economists see a certain philosophy—the redistribution of wealth—underlying most of our recent national legislation. At least, it indicates that the government now deals with many more things touching the daily lives of people than it did formerly, and that people are aware of this and are accepting the fact. If a change in the philosophy of

government is beneficial to people, may not a change in the economic philosophy of medicine offer a chance for improvement in medical economics?

The difficulty of bringing about an improvement in medical economics along the lines which have guided the relations of medicine in the past, is arousing a good deal more thought than it did a few months ago. If free medical care is to be continued to any class of people, the cost must be met by the public and not by the doctors. Into this picture comes *the State* to the extent of taxation—one of the things that prevails so largely in Denmark.

The profession of medicine has always gone along with the social condition of the people it serves, and probably will continue to do so, with the modification of certain details. The professional side of a physician's life is established in public confidence.

Dr. Howard W. Haggard said in an Address to the New York State Medical Society during its Annual Meeting in 1933: *"The average level of medical practice never gets far from the level of its public. * * * We talk of the public's regard of medicine, but in doing so we forget that the physician himself in any period is a product, is a part, of that same public. He has grown from it, his ideas and his ideals are colored by it. The state of the practice of medicine at any period reflects the state of the public; the public's attitude toward medicine reflects in turn precisely the regard in which the physician himself holds his own calling. When he regards it as an art or a religion he is venerated. When he holds it as a trade he is treated as a tradesman. When he holds it as a science he is treated as a scientist."*

II.

ARE WE APPROACHING A NEW ERA IN MEDICINE?

J. Bennett Morrison, M.D.,
Secretary of the Medical Society of New Jersey,
Newark, N. J.

I deem it a great honor to be chosen from among you by the Program Committee to take part in this discussion tonight. While it is true that I have given these topics a great deal of study during the 10 years which mark my term of service to you in the office of Secretary; that I have watched with increasing satisfaction the development of *Public Relations Committees* in almost all of our Component County Societies; that I have seen the programs of County Societies altered to include free discussions of the economic problems of the day; and that I have seen physicians all over the State taking a far greater interest than their forebears in organized medicine; I do not feel any better qualified to take part in this program than are many of you here present. After listening to Dr. Ross on the Report on the Costs of Medical Care, I shall attempt to avoid tiring you with mere repetitions, and will make my remarks brief and concise, and I trust that the brevity of my remarks will add to the force of my arguments.

Some of you who attended the meeting of the House of Delegates 2 years ago will recall my prediction—*that we would be face to face with socialized medicine within 5 years.* Well, it has come 3 years earlier than even I had anticipated. This *Report* has done more than anything else in the past 10 years to bring socialized medicine distinctly *in the offing* in America. You will recall how it spread over Europe until it is now in force in almost every country on the Continent. The claim has frequently been made that *it could never flourish in America:* our "living standards" were different; there was no abject poverty; we had no paternalistic tendencies and the laborer in this country wished to stand on his own feet and pay his bills. Well, within 2 years it has come to this country, has jumped across the Atlantic and spread like a prairie fire all over Canada, until it is now in force, or about to be put in force in the Provinces of British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec; a list of Canadian Provinces which stretches across our northern border.

Those of you who have traveled through Canada will recognize the fact that, except for the Province of Quebec, the people there are of the same racial stock that we are; their living standards are like ours; their social and industrial problems are ours; their industrial

and agricultural difficulties are ours; and, the only difference you will notice between that country and this is in the arrangement of the red, white and blue colors in our national flags.

What is to hinder socialized medicine from spreading across the border into our adjacent States where the economic problems are exactly alike?

The American Medical Association already considers the Pacific Coast States lost to organized medicine. West Virginia and Massachusetts are said to be about to follow. Bills favoring socialized medicine have been introduced in more than a dozen of our States during the past 10 years and the supporting arguments are gathering force with every year. How much do you think this *Report* and the markedly socialistic ideas of some of the signers of the "majority group" will aid the advocates of *State medicine?*

I greatly fear that the American Medical Association stepped off on the wrong foot in its attitude toward the *Report*. Instead of offering conservative coöperation it has aroused bitter antagonism. The day after the Fishbein editorial appeared in the Journal of the Association, there was published in the New York Times a bitter, vindictive attack on our leaders at Chicago. They were accused of being a conservative bureaucracy, and the writer said: "If any one is looking for a fight he can have it." The Committee on the Costs of Medical Care has passed out of existence but we are led to believe that those members of the old Committee whose minds are dominated by socialistic tendencies are still banded together to bring about socialized medicine. And they will have all the financial support they wish. This group, through one of its exponents, said: "All the technic of modern adult education will be utilized to offset the possible pressure of organized medicine to impose its self-interested will upon the people." One of them said also: "Group payment and group practice are essential for the further development of medicine in the United States." Has the significance of those statements made the same deep impression on you as upon me? To the speaker they mean that the medical profession in the United States is to be confronted by a gigantic war, in which every modern method will be utilized to bring about the establishment of social health insurance, and our enemies consist of powerful welfare groups, social agencies, college professors, prominent lawyers, engineers, captains of industry and magnates of commerce, backed by an almost unlimited sum of money. They would appear to be ready to force the issue whether or not the medical profession permits.

At the annual meeting of the Milbank Fund, held at the Academy of Medicine in New York, March 16, 1933, the President of that fund made an outright appeal for the establishment of compulsory health insurance by State legislatures.

If and when they have educated the American public to adopt their beliefs and doctrines, what chance will our 150,000 physicians have against the will of 120,000,000 people, even if we are organized to a man? Fortunately, almost the entire press of the country is on our side and that will be a valuable agency if we have to resort to its utilization.

The American Medical Association favors the development of some plan or various plans formulated by County Societies, such as the Iowa and Michigan plans. For those of you who are not familiar with those plans, I shall discuss them briefly. The *Iowa plan* has been in existence in that State for 15 years. Under it the municipalities pay directly to the County Societies sufficient money to defray the cost of medical care of the indigent. If this plan were extended to cover the middle classes the municipality or State would have to pay the bills. This would be pure socialized medicine.

The *Wisconsin plan* is as follows: A somewhat different type of insurance to cover the high cost of medical care was proposed during the Summer and Autumn of 1932 by a committee of the Medical Society of Milwaukee County, Wisconsin. The Committee suggested formation of the "Community Medical Service of Milwaukee". A joint medical and lay Board was to enroll individuals and groups of persons who would pay regular monthly dues (based on income) in return for definitely designated medical services. These services would be provided by any member of the County Society utilizing the plan. Subscribers

would be allowed free choice of physicians and institutions participating in the plan.

It is expected that indigents would make no payment of monthly dues but would receive services from the tax-supported hospitals and dispensaries. Limited sums might be paid from taxes to the Community Service for the work of physicians in the homes of the indigent patients. A non-resident subscriber, when sick, must purchase medical care direct from his doctor, in the usual manner of private practice, up to a certain amount in any one year, before he would be entitled to medical services under the plan; the amount of medical care to be paid for by these individuals to be determined in proportion to income.

The net result of the financial arrangements would be to protect the subscriber and his family against only the burden of catastrophic illnesses. Simple types of illnesses would continue to be paid for on a private fee basis, unless a succession of such simple illnesses in a family brought the total yearly expense beyond a specified limit. Preventive services, except those required after the limit had been reached, would not be financed out of the regular monthly dues.

This plan is the best grist that has come out of the mill which is grinding the wheat, chaff and noxious seeds of the *Report*. We may later have copies of the plan mimeographed and sent to the County Society Committees studying these problems.

The *Milwaukee plan* keeps the sum subscribed and paid in, and all the medical care rendered, in the hands of the Community Service. There is no chance for competitive insurance companies offering the same benefits unless they secure the medical services of physicians outside the County Medical Society. It allows free choice of physicians and hospitals. It permits the laborer with a small salary to maintain his independence, while securing adequate medical care for his family; and it provides for the indigent. It would seem probable that this plan, if once properly instituted, would be widely followed in the United States. This plan has not yet been carried into effect, and it must be stated that no County Society in America has, as yet, endorsed the voluntary medical insurance principle. I am offering it for your consideration.

Still another plan, with much in its provisions to be commended, is in force among the employees of the Union Carbide Company, of West Virginia. Employees carry a Group Life Insurance Policy with the Metropolitan Life Insurance Company. All dividends from this Group Policy are placed in a "special fund" managed by Trustees elected by the employees. An employee is permitted to borrow from this fund to pay for medical and hospital expenses. He is charged 4% interest and is required to repay the amount by pay roll deductions within 52 weeks. There is absolutely free choice of any physician or hospital in the community. The plan has no obvious defects from either ethical or practical standpoints. There is no profit distributed, either to organizers or to managers. A life insurance contract is an integral part of the plan.

It would seem that this plan should be adopted more widely among employees of industrial plants where occupation is continuous.

After a thorough study of the *Report,* I am now convinced that no national plan short of socialized medicine can be universally adopted. So, it behooves every County and State Society to work up some such plan as those enumerated, which will be applicable to an industrial or an urban locality and meet the necessities and requirements of local conditions.

While I gather the impression, as I travel over this State, that many members of the profession would prefer that the discussions died down and things remain in *status quo,* I cannot help but believe that such a plan of procedure would be fatal to our interests and that we will be compelled, in the near future, to propose and adopt some plans of relief.

It has been claimed that the time was set by the Committee to render the *Report* so that it would appear at the very depth of this period of depression. A little analysis will disprove any such statement. You will remember that the Committee was appointed in 1927 to serve for 5 years. Now, the years 1927, '28 and '29 marked the very *zenith of prosperity* in this country, yet the question of high cost of medical care was acute during this period of unusual prosperity. The *Report* was pub-

lished at the close of the 5-year period and, by mere coincidence, appeared during this severe depression.

The *Report* advocates "group practice centered around hospitals". In some of our smaller Counties in New Jersey, with hospitals centrally located or evenly distributed, this might work, but how would it apply in, let us say, the State of Texas, with its expansive territory and long distances between towns? Even if the number of hospitals were increased 3-fold, it still would not work. Enormous expense would be incurred in transporting patients to the central hospitals, even if patients would consent to go so far from home, and where relatives could not visit them. How could it operate in the vast agricultural and mountain stretches in our Middle and Western States?

The *Minority Report* suggests progressing with our present system, rather than trying new methods based largely on theory and revolutionary ideas, and that whatever new method is offered should be based first upon sound experience and that we do not lose certain values that have accumulated during the centuries. The *Minority* Group calls attention to the fact that the *Report* depends too much on group practice, group payments and mass production in medical care, instead of the individualistic practice of the present day.

They recommend that the Federal Government shall diminish rather than increase its incursions into private practice and that both Federal and State Governments should defray the cost of medical care to indigents. In all institutions where the indigent are cared for, apart from State institutions, everybody from the Superintendent down to the scrub woman is paid for his or her services—except the physician.

The *Minority Report* does not offer specific plans for the future, as does that of the *Majority*. The signers of this report wish the medical profession, rather than the laity, to make a profound study of the matter and that the physicians shall come to their own conclusions as to what are the best methods to be advocated and adopted.

Both reports advocate retention of the personal relations between physician and patient, but how this could be maintained in mass production of medical service and in the extension of group and clinic care, as advocated in the *Report,* I do not see.

The *Minority Report* points out the dangers in group practice. The medical group may become so large that not only patients but some of the physicians may become mere cogs in a machine and all personal relations of any value lost. Some physicians may lose individual initiative if their existence is assured by a group and they no longer have to compete with their fellow physicians. Even in medicine we cannot get completely away from the ideas that "competition is the life of trade" and that "great combinations stifle initiative". In group practice, the desire of the older men to keep their grip on power, and the desire of the younger and more ambitious men to attain it, can be more effectively destructive within an organization than between independent competitors.

Hospitals should be opened so that every licensed practitioner in the community, whether or not he belongs to the County Medical Society, should have the opportunity to secure accommodations for his patients and should, under proper supervision, be permitted to administer to their care. There is too much of the *closed shop* of trade unionism in our hospitals today.

Let me warn you that organization in medical care is bound to come through private initiative or through initiative by the government. Whether it comes through governmental or non-governmental agencies, will depend upon the interest and activity of the members of our profession.

After a careful study of these several reports, and a perusal of the many recommendations, the action to be taken by any State Medical Society may, in my opinion, be condensed into a single paragraph. "The crux of the whole situation is this. Some plan must be devised by which the great mass of the American people, 80% of whom earn less than $2500 a year, may receive *adequate* medical care at a price such people can afford to pay. And this does not mean medical frills, elaborate roentgenographs and laboratory examinations, but means simply *adequate medical care.*"

The average cost of medical care to the American citizen is from $20 to $50 a year. If the family consists of 2 parents and 3 children, this means an outlay of from $100 to $250 which must be met every year. These citizens do not budget their expenses and when the demand comes for this outlay, the laborer cannot meet it and continue with the general support of his family.

Our profession is properly to be criticized for a very considerable increase in the cost of medical care. We have educated the public to believe that we cannot make a diagnosis in their illness unless we employ the same methods of examination and investigation for which the wealthier class can afford to pay. And, so, they come to us demanding an x-ray gastro-intestinal series and a variety of laboratory reports. Many of us older physicians have successfully diagnosed and operated for the removal of biliary and renal calculi before the days of discovery of x-rays and renal and hepatic functional tests. Do not misunderstand me. I do not belittle the value of these aids to diagnosis, but I believe it is not absolutely necessary to employ them in every case in order to establish a working diagnosis. We are drifting away from education of the 5 special senses. The trained eye, the trained finger, the trained perception and intuition, the profound deliberations and deductions upon which the "Doctors of the old school" depended in arriving at their diagnosis, are now far too often supplanted by laboratory and x-ray investigations at a considerable expense to the patient.

A little analysis of present conditions will demonstrate that State medicine is, to a large extent, here today. By changing some 20 or 30 words in our Workman's Compensation laws we could make *socialized medicine statutes of them.* Our insane, tuberculous, feeble-minded, epileptics, sufferers of contagious diseases, whether they are or not able to pay, are cared for by the Government. Our vast army of soldiers, marines and veterans are already given medical care under government administration. The physical examination of school children, the medical care of policemen, firemen and, in some cases, of civil government employees, are instances of *socialized medicine.* Already 73% of the available hospital beds in America are filled with patients under municipal, State or federal care. And who has made this possible? To a large extent, members of our own profession.

Already, all over the United States, and especially in New Jersey, *hospitals are forming voluntary insurance associations* where, by the payment of $10 a year, individuals will be *guaranteed hospital care,* in a private room, with all the usual hospital and nursing attention. If this proves popular, how long do you think it will be before the *public will demand medical care* on the same basis? This will mean *voluntary health insurance* somewhat like the Wisconsin plan. If it could only be maintained on a basis where adequate medical *care of a high standard* would be furnished, it probably would prove satisfactory. But, unless a composite Board of physicians and laymen had control of the funds, and the medical services were rendered by a group this Board could control, then, just as Insurance Carriers, under our Compensation Laws, engage the services of poorly educated and inexperienced physicians to render medical services at *cut rates,* the *quality* of the service would, of necessity, deteriorate. This is just what has happened in most countries where *voluntary* insurance plans have been tried.

So, with our professional anchors slipping; with members of our Society engaging in contract practice, in insurance schemes of doubtful value, in the Workman's Compensation rackets, which in New York and New Jersey are a disgrace to our profession; with a growing dissatisfaction shown by the people in the older methods of administering medical relief; with rapidly changing social and economic trends; *some change in the administration of medical service must be expected. Can we control this necessary change?*

I am not an advocate of socialized medicine, nor do I subscribe to the *Majority Report.* I *am an apostle of preparedness* and I sincerely believe that unless we adopt some plan or policy which will put an end to the criticism of our profession by the laity, which is steadily growing more bitter, we will be driven into socialized medicine. As I have said previously, when we refer to *socialized medicine,* the en-

tire profession sees RED. May I remind you that such was just the attitude adopted by the profession in foreign countries. And what happened? The governments (the politicians) *forced socialized medicine upon the profession* and the latter had no voice in the preparation of those laws.

If medicine in America were socialized, and the average outlay of $35 as set by the Committee on the Costs of Medical Care, were taken as a basis, then to cover the 80% of individuals who earn $2500 or less a year would require an outlay of $3,360,000,000 annually by the government; and would represent an increase in taxes of 40%.

Ultimately, this enormous burden would be shifted upon the consumer. The increase in taxes would be reflected in increased rents, and the rest of the revenue from all sources would be reflected in increased cost of commodities. When the average citizen is given to understand these things he will "blow cold" to socialized medicine as a federal proposition.

If we were living under a socialistic system, and the practice of medicine had, for some reason, been excluded for a time, and if then a proposition was made to socialize medicine as well, I would go along willingly. But why pick out medicine first for this "noble experiment" in socialism? Why not socialize the lawyers or the civil engineers? Why not completely socialize education? Why not socialize all methods of transportation, the public utilities, the great food industry, and let all the present millionaires, and all members of the wealthy class have their incomes reduced to the level of physicians? It would stifle initiative but it would at least put us all on a level.

I do not believe that socialized medicine will ever be introduced in America as a Federal proposition. If it comes, it will be in spots; the radical States proposing it first. If we fear the introduction of socialized medicine in America, then it behooves our profession to clear up our conceptions of State and socialized medicine, get rid of our ignorance in regard to both systems, and make a thorough study of both *without prejudice or bias*. State medicine, as I understand it, is in operation in Russia only. There, the government says to Dr. Ivan Ivanowitz: "Doctor, your income from the practice of medicine in this country will be $2000 per annum in the future. You will have no private practice. You will be an employee of the government and will conduct your practice as we dictate." Socialized medicine, or socialized health insurance, on the other hand, is a system where the money for medical care is raised by an assessment of the employee, the employer, and in some instances part of it advanced by the government. The doctor is not a full time employee of the government. Not all physicians go on the panel system in any of the countries where socialized medicine is in force. The people treated under this system are only those whose wage return is less per annum than a stipulated sum. In Germany, this wage limit is $858 per annum. Broadly speaking, health insurance as now in force in Great Britain, is *compulsory* for all workers with a maximum income of $1127. In Denmark, the annual income limit varies from $750 in rural districts to $1126 in industrial centers. This is for single workers. There is an increase of $80 for each dependent child under the age of 15, and the present capital limit above which the worker cannot secure medical services or benefits of any kind under the system, is $2540 for persons without dependents, and $3752 for those with dependents. I cannot give you the exact figures for France but they are about midway between those of Great Britain and Denmark. One of the inherent evils of the system in all these countries is that health insurance, that is medical attention, is tied up to cash benefits for loss of time.

I understand that now in Great Britain, the malingering has been so great, both for illnesses and loss of time, that the matter of adjustments is being taken out of the hands of the doctors on the panel and the applicants are dealt with by a separate board of medical examiners appointed by the medical profession. Since this plan was instituted the number of applicants and the amount of remuneration have fallen materially. The number of insured in Great Britain is now 15,000,000 out of a population of 50,000,000; so as you see, more than 2/3 of the population still is served medically under private practice.

Prior to the introduction of health insurance in Great Britain, the laborers belonged to Friendly Societies, where Society doctors gave them medical care at a stipulated price of a few shillings a year. This was similar to the "lodge practice" in many of the industrial centers in New Jersey 20 years ago; and we all are familiar with the character of that type of medical attention. The laborer had his "lodge doctor", who received from the Lodge $1 a year per family for ordinary minor medical care but when any real illness came in the family of the insured the patient employed a "real" doctor and paid him, himself, or attempted to do so.

From Americans who have made a study of health insurance in England; from relatives of American physicians who are in practice, on the panel system, in England; from an English maid, working in my own family, who was treated under the panel system for many years following its adoption in 1911; I learn that the laborer in Great Britain receives from 100 to 300% better medical attention under the panel system than ever before. Where the doctors used to have a precarious income from this class of patients, they now received from $1500 to $2500 a year for treating the same class of patients. During this great world-wide depression such practice has been a God-send to the physicians. Remember, too, that a physician "on the panel" may accept as many or as few individuals up to 1500 on his panel as he wishes; and a great many of them have no panel work at all. When we consider that in normal times and in the absence of severe epidemics only 1% of the population is ill at any given time; the burden of a panel is not very great. So, the patients are better treated and the doctors are better paid.

When you ask an English physician if the statement so often heard in America, to the effect that the physicians are deteriorating under the panel system, is or is not true, he takes it as an insult. He will compare the books compiled by English physicians, the literature in journals, the amount of investigation being done in laboratories, the hospital statistics, the scientific work of the British Medical Association, with those in America and will convince you that the physician in England, after the panel system has been in force for 22 years, is still on a par with the average American physician in his mental attainments, medical knowledge, scientific work, and general culture.

I have made rather a deep study of these systems abroad, not that I am an advocate of socialized medicine—for I wish it distinctly understood that I am not—but because, if and when, we are threatened in America with the imposition of socialized medicine we should understand the system as it is applied in Europe, be acquainted with its desirable and undesirable features, and be in a position to assist, with an intelligent understanding, in the drafting of statutes that may be proposed in this country.

We cannot continue to drift along in our present ignorance, and yet we look in vain in the medical journals published in this country for any reasonable or just or fair description of the system, or of its results in so far as the laborer or the physician is concerned.

So we must secure the literature being published now in America, and there is plenty of it, and come to an intelligent understanding of the advantages and disadvantages of the system at first hand and not rely on hearsay or even distorted reports.

Someone must bring the basic points in these systems to your attention, if we are to make an intelligent study of them, and as your Secretary, I am laying this brief outline before you, not as any conviction of mine, not with any advice of mine, not with any plan of mine, but simply as an endeavor to induce you to investigate for yourselves if you feel that the foundations of the administration of medical relief in this country are in danger of being swept away.

In New Jersey, at the present time, there are more than 1,000,000 people receiving charity from the State on an organized plan. About 140,000 families have no visible means of support. The medical profession has been requested to assist the Emergency Relief Administration by rendering medical aid to these indigents at about 2/3 of the usual fees for office and home visits. The government of the State is making these payments. So, it is per-

fectly evident that the "dole system" has been inaugurated in New Jersey, and that socialized medicine has, also, been introduced. It is more than possible that if this depression and extensive unemployment continues, the government will not be able to finance the medical care of these indigents at the present rate and will then be compelled to propose a "panel system". Leaders in sociology and the members of the legal profession express the opinion that medicine, and many of our industries, will shortly be socialized. Even the osteopaths and chiropractors see it coming and are introducing bills in our legislatures to make them full-fledged physicians before the deluge comes. Our medical profession is the only group which cannot, or will not, see "the handwriting on the wall".

I am urging you now to outline in advance some campaign of action. This is the strategic attitude which any competent military general adopts. I ask you to remember that whatever plan you devise cannot have nation-wide, nor perhaps, even State-wide application, short of socialized medicine. The plan applicable to Perth Amboy will not apply in Salem; what may be a satisfactory solution in Atlantic City will not work out in Essex County; and the plan which you may devise for Hudson County will not be applicable in Sussex.

Broadly speaking, we should plan for survival of the best form of medical care as it is administered today, and which has survived 1000 years; provide for survival of the individual physician and his relations with his private patient; see, in whatever plan you advise, that no third party, or committee, or society, intervenes between the physician and his patient; see, as the profession did in France, that the physician receives adequate remuneration for his services; that provisions are made for vacations under pay; that provisions be made for post-graduate instruction; and that whatever legislation may be proposed shall be adopted only after thorough consultation with the profession and that the set-up of boards to administer the plans is in the hands of physicians, or largely so, and that payments for loss of time are entirely separated from the medical relief plan. Then, keep this plan ready for use if and when it becomes necessary. This is the only logical, common-sense course to pursue. If we do not make such preparations, but maintain our present attitude—that we will have nothing to do with health insurance, either voluntary or compulsory—we will be "ground between the upper and the nether mill-stones".

In the past, we have distributed some very valuable information to the members of our society in the form of our "Primers". I believe that the Officers of the Medical Society of New Jersey should instruct some member, or some committee, to prepare such a "Primer" dealing with this grave economic problem. The greatest possible amount of information should be disseminated among our members, for, in the opinion of the speaker, we are on the very threshold of socialized medicine in the State of New Jersey.

DISCUSSION OF OUR ECONOMIC PROBLEM

John A. Hartwell, M.D.,
New York City

It is hardly to be expected that anything definitely final can be advanced for solving the problems that have come to the consciousness of the country as a result of the report of the Wilbur Committee. It is interesting to note that this group worked as the "Committee on the Costs of Medical Care", whereas the title of the final volume giving that report is "Medical Care for the American People". This differentiation is one of importance.

From the reading of the various preliminary reports published by the committee, one gets the impression: that the original intention was to find a means for an adjustment in expenses connected with sickness. As the work of the committee progresses, however, this economic phase is found to be so closely bound up with the question of adequate medical care that some confusion in the work resulted and led to what everyone now acknowledges as the unfortunate incident of conflicting majority recommendations and minority recommendations. It will be helpful, there-

fore, if we first can succeed in clarifying some of this confusion by looking at the situation from the standpoint of the real objective.

There has gradually arisen a conception in all civilized countries that adequate medical service to the individual and the community is a requisite of a desirable social status. It is not quite so clear, however, that the factors underlying this conception are understood.

Sickness undoubtedly is a serious charge upon the individual and in many instances may become a charge upon the community. When society demands adequate medical service for the individual, is this demand based entirely upon economic grounds? I believe not. More than 40% of all hospital beds in this country are reported to be occupied by patients suffering from mental derangement. There is an insistent demand that the care of these patients should be of the highest type and yet it is quite apparent that, with our present knowledge, only a very small proportion of this vast number can be restored to a sufficient degree of mental health to make them an economic asset to the State. Again, society has long acknowledged its obligation to take care of the indigent during sickness and it is now also acknowledging its obligations, during this period of unemployment, to give at least shelter, food and clothing, and in some places medical care, to those temporarily indigent. Other factors than economics are involved. Society is motivated by 2 very definite ideas. One is fostered by economic aspects and the other by the humanitarian impulse.

It would be very helpful if one could know what was the relative value of these 2 conceptions in the minds of the gentlemen who originally met in Washington on April 1, 1926, to consider what they speak of as an "unsatisfactory situation". A reading of their introduction indicates that they were largely concerned with the economic problem connected with sickness and the impossibility of adequate medical service being rendered to a considerable portion of sick persons. They recognized the fact that, in the last analysis, such medical service could only be rendered by the medical and allied professions and that, therefore, the economics of the situation must include consideration as to how these professions were to be compensated for their services.

If we are to arrive at a solution of this very complex problem it is necessary that we begin with a clear understanding of why the problem must be solved. It must be recognized that a number of diverse opinions may be involved in the desire to find such a solution. Those who are concerned with a strictly economic return demand that good medical service be rendered to the individual and the community because, in the end, they feel the property interests of society will be better served. Those who are concerned more with the humanitarian view do not give the same consideration to the economic problem but demand that the sick be properly cared for in a Christian way because they are averse to suffering. They do not care whether or not the financial outlay is greater than the monetary return, for their ultimate purpose is to achieve a happier rather than a richer world in which to live. If these points of view could be accurately evaluated and integrated, we should be in a position to think more clearly concerning the whole problem. It is to be noted that if the economic side be carried to the extreme, a great deal of suffering may go unrelieved in an attempt to seek adequate "property return" for expenditures made. On the other hand, it is equally apparent that if the humanitarian feeling be carried to its extremity, it may become so vastly expensive that it will defeat its own end by placing the burden of its cost upon the shoulders of those who are financially able not only to care for themselves but also able to aid in the care of others. Too great a demand upon this class may be as much a source of suffering to them as the unrelieved stress of illness may be to others.

There is some evidence that this state of things is rapidly approaching because of the demand that sick persons shall be cared for not only with the intention of restoring them to health as quickly as possible, but with the thought of providing them with an environment far superior to that in which they are accustomed to live when well.

Behind the movement to bring about changes in medical practice at this time, we may there-

fore expect to find economists, humanitarians and social reformers. Possibly also those who, by education and training, find it incumbent to provide an outlet for their capabilities, by stimulating study and change because of that common attribute which impels the individual to work in that field in which he feels himself to be best equipped.

The medical profession must recognize itself as the tool with which these various social agencies expect to work. The rôle the profession is to play is its concern. As independent individuals they claim the right to work as inclination dictates. It is quite possible that this feeling is augmented by the fact that, in the majority of cases, the doctors have accustomed themselves to independence of action exceeding that of any other group. As has been so constantly pointed out, a doctor is an *individualist* and has fitted into his place in society with less necessity for adjustments and compromises in his activities than almost any other group of persons. He has, to be sure, accustomed himself to work in universities and hospital organizations, and has conformed to essential requirements of such organizations. However, this has been done quite voluntarily by him and he has been a largely uncontrolled, dominant factor in formulating the conditions under which he has worked. This has given him an independence of spirit which makes it exceedingly repugnant to him to be asked to conduct his life under supervision by outside influences of which he is not the master.

A small number of the members of the profession, at the present time, are engaged in so-called full-time occupations where they have given up a certain amount of this independence. But the majority still desire and enjoy the entire freedom and independence which the private practice of medicine permits. Inclination and self-interest are the determining factors in the question of how the individual shall work, when he shall work, what shall be the environmental conditions under which he shall work. It is, therefore, exceedingly hard for him to realize and accept the fact that an entirely new force is coming into play. This force is the demand of society, as expressed by the economists, humanitarians, and others, that the practice of medicine is their concern as well as that of the medical profession and that the latter must adjust itself to this demand. In other words, if the medical profession intends to continue as leader in all matters pertaining to health, it is emphatically demanded that it return to society that which medicine was created to produce. We, therefore, are concerned with an adjustment of what may appear to be conflicting sentiment if not conflicting interests. Those minds which I conceive to be the wiser in the medical profession have arrived at the conclusion that, in the long run, society will in one way or another, get from its component groups, including the medical profession, what it wants to get rather than what the component groups would like or are willing to give.

We are now passing through a phase in which this concept is being rather forcibly demonstrated in many of our institutions. My intention might be misconstrued if I named specific examples. However, my audience will find no difficulty in supplying them if it studies present trends in Washington and State capitols, toward the control by governmental agencies, of various groups which heretofore have been much more powerfully entrenched than has the medical profession; because society is demanding of its agents that these groups shall serve it rather than serve their own interests.

One seems justified in believing that these groups would be much happier at the present time if they had listened to the rumbling of the storm before society, through these agencies, took matters into its own hands and proceeded to force adjustments.

If I have succeeded in drawing clearly for your inspection the picture I have in mind, it will appear that, in my belief, it is advisable for the medical profession to discard all that is counter to the interests of society and to formulate policies which will give to society the return it demands.

The corollary to this is that the medical profession must become a dominant factor in determining for society what society really needs, and not what it may think it needs, because of incomplete knowledge of the facts. I am strongly of the opinion that the most destruc-

tive way to attempt this is by quarreling among ourselves. It is my belief that a very valuable service can be rendered, at this time, by making an earnest effort to view the situation without prejudice, and to attempt a proper evaluation of the differences which seem to have arisen within the profession itself.

For this reason, I appear before you neither as an advocate of the "Majority Recommendations" nor of the "Minority Recommendations" in the Wilbur Report. Rather would I attempt an analysis of the whole situation with the desire to pour oil on the troubled waters and to persuade the doctor that there is not sufficient difference between them to justify any quarrel. A careful reading of the *Report* puts one in possession of very valuable facts. It would be a great misfortune if this value were dissipated in an acrimonious discussion as to whether the lesson to be learned from these facts leads in one direction or another, as determined by groups who apparently permitted themselves to be guided more by preconceived notions than by logical conclusions resulting from careful study. In addition to this, if one will take the trouble to use the *deadly parallel columns* in determining the intention of the "Majority" and the wishes of the "Minority", it is striking how nearly these are in accord.

For example, the "Majority Report" talks a good deal about the necessity of centering around a so-called medical center (meaning thereby usually a hospital) and proposing that the expense connected therewith shall largely be met by some form of insurance by those to be benefited. But they point out with emphasis that, if this plan is to succeed, strict safeguards must be set up to avoid evils inherent in any form of insurance.

The "Minority" recognizes the values of such group insurance around a so-called medical center and points out very emphatically that the dangers inherent in this can only be avoided if definite safeguards are established. In other words, the "Majority" urges movement along certain definite lines, but with great caution to control inherent dangers; while the "Minority" urges caution in moving along these same definite lines and emphasizes that safeguards must be set up unless the inherent dangers should overwhelm us. Possibly I am somewhat epigramatic, in stating the position in just this way, but I assure you that if you carefully study the *Report* you will find full justification for believing that the underlying viewpoint of the two groups is not nearly so far apart as it would seem, when one picks out only the statements made by each and neglects the qualifications pertaining to them.

Both groups are agreed that sick people should be taken care of. Both groups are agreed that the medical and allied professions must furnish the skilled labor to do this. Both find advantages and disadvantages in doing this under what might be called corporate facilities. One group believes that a great deal of lay help will be necessary but that the independence, the freedom of action, and the individual responsibility of the doctor shall not be hampered. The other believes that the medical profession had better handle the whole situation, so far as possible, but judging from present trends no doctor can believe that he can fulfill all that is demanded of him except by the aid of outside agencies.

One group sets up the *medical center* idea and the other believes that the *county medical society should be the medical center.* There is not sufficient conflict between these 2 groups to make them mutually exclusive.

In the Wilbur Report there is described a variety of plans already in existence for solving the problem; these methods are working with more or less success. Both "Majority" and "Minority" Reports advocate the careful study of these plans as they already exist, and their enlarged utilization under different conditions, with a view to determining more extensively what is good and evil in their administration. It may be that the very expanse of our country, with its entirely different conditions in separate communities, adds a complication in arriving at a national method which will prove satisfactory. On the other hand, there is a definite advantage in this situation because there is ample opportunity to study conditions and set up trial plans which may seem applicable to localities having like conditions.

In this way, in the course of time, there will evolve satisfactory methods and from these

will grow a wider extension so that, in the end, our objective may be reached.

It will clarify the issue if we recognize that the whole problem divides itself automatically into separate units. First, there is an almost universal concern for what we have come to know as "public health and community hygiene". It must be acknowledged that the profession has lagged behind other agencies in the development of this particular field; not that leaders in the procession have failed to take their full share of responsibility, and to bend their efforts in this direction: but in that the rank and file have remained much more individualistic in their outlook and have not given that consideration to public health matters which their interests and those of society demand. It cannot be denied that the average general practitioner has, up to now, paid less attention to preventive medicine, both in its individual and in its general application, than is desirable. It is well known by public health administrators and governmental agencies that it is not an easy matter to find men, trained in the general field of public health and preventive medicine, to fill important "key" positions. A glance backward at the period of formal medical education, through the medical college and internships, will convince most of us, and even those among the younger group, that scant emphasis was laid upon this aspect of the problem.

The Wilbur Committee finds that public health service expends only 3.3% of the total cost of medical care. It is obvious that this sum is not sufficient to carry forward a program of preventive medicine as rapidly as the needs demand. If ever we are to be relieved from the burden of occupancy of more than 40% of our hospital beds by patients suffering from mental derangement, it can only be accomplished by preventive means. We are entirely too prone to accept mental breakdown as an inevitable fact, and to treat it after the event. This defeatism viewpoint cannot be justified.

One of our grave concerns, therefore, is that the profession be aroused to a greater concern in this phase and other forms of preventive medicine and asked to strive toward a solution. It undoubtedly will prove to be a fact that the greater proportion of those actively engaged in public health must give up the individualistic attitude and become public servants under governmental control, because much of the work to be accomplished in this field can only be accomplished as a government function. However, if the profession in general takes an intelligent view concerning this question, it can guide events in such a way that those doctors who are responsible for such service will work under conditions freed from the control of politics, and will be granted an independence of thought and action which will attract many of our best minds, which, in fact, has already occurred under far from favorable environment.

But in the domain of private practice it is also necessary that the individual doctor develop a mental outlook which keeps before him constantly the necessity of guiding his patients in the way of health before they, through insufficient knowledge, actually suffer from illness.

Our people are divided into 3 distinct groups when an attempt is made to solve the problem of giving adequate medical care to the sick person. There is that group which is able and willing to pay for any medical service required. It is from this class that the majority of practicing physicians have derived the bulk of their income. There has developed the so-called *sliding scale of charges* which works satisfactorily for the most part. It is true that medical men are not good business men, and are rather careless concerning their incomes and expenditures. With some experience, however, and a knowledge of the financial status of the client they, on the whole, arrive at an accurate evaluation of the service rendered and make a charge which is acceptable both to the patient and to themselves. Considering the volume of business that is done, serious disagreements concerning charges are quite uncommon between patient and doctor. On the other hand, adjustments of what might become serious disputes are made daily in the doctor's office, and through mutual cooperation, mutual good will is maintained. I can find nothing in the recommendations of either the "Majority" or the "Minority" which

indicates that any fundamental change should be made in this plan.

As we approach that group in society which is less financially independent, the difficulties of the *sliding scale system* become greater, and here, undoubtedly, the doctor frequently has to give his services with a remuneration far below a just return. But, the volume of this work is great, and, in consequence, the financial return to the doctor is, in the majority of instances, sufficient for his requirements and permits him to live as his training and natural endowments entitle him.

A consideration of the situation as we descend in the scale of earning power brings us to the most serious level of our whole problem. A reading of the "Wilbur Report" demonstrates convincingly that the concern of the committee was largely with that group of society which, under normal circumstances of health, earns a sufficient amount to meet all ordinary requirements and possibly have a surplus, but under conditions of sickness this surplus is insufficient to care for the necessary additional expense of adequate medical service. Even among this group, however, most illnesses can be properly cared for, and it is only when the illness requires especial care over a long period of hospitalization that the burden becomes severe. Constructive effort will more certainly follow if those who attack the problem recognize that the necessary changes in our present methods should be made with reference to this economic group in particular.

Below this group lies the definitely indigent, whose income is so low that medical care for all illness must be furnished at the expense of the public.

To recapitulate, there are 4 divisions of the problem before us—only 1 of which calls for extensive readjustment under present conditions.

(1) The public health problem.

(2) The care of those who are and can be adequately provided for under the sliding scale system.

(3) Those who are on the border-line and need additional care for which they can not pay from their limited earnings.

(4) The fully indigent who can pay no part of the cost of illness.

It is with the third group that we are most seriously concerned—that group which makes up the greater part of the population and, therefore, in the volume of work to be done occupies the premier position. Considering for a moment the fourth group, undoubtedly, with more efficient management, the indigent could receive the care they require in a much more efficient way and at a decreased expense. It is important that the medical profession take cognizance of this and work toward these ends. Just what the total cost for the care of this group amounts to at the present time is not known. It is met by taxation, in the case of our municipal and county hospitals, and by voluntary contribution in the case of the "private hospitals".

Formerly, the care of these persons within the hospitals and the free Out-Patient Departments amounted to sums varying from $1.50 to $4 per day. Now it has mounted to more than twice this. It is important to know whether this increase has been due to rising costs for ordinary living or whether other factors have entered into the situation, the elimination of which would in no way be detrimental to the interests of the patients.

Another phase of this situation, in which the medical profession is itself interested, has to do with the question of whether the traditional policy of non-payment of the doctors, for the care of this group of patients in Hospitals and Out-Patient Departments, shall continue. Traditionally, this has occurred because the medical profession enthusiastically sought and accepted positions in these hospitals, both municipal and private, without such remuneration because of the prestige and experience arising therefrom. The time has now come when it is necessary to review this situation and determine to what extent traditions should be discarded and a new arrangement entered upon. It is a matter worthy of the most serious consideration by the profession itself, and it is more than probable that there will result some conflict with the laity because the latter will be loath to pay from public taxes or private contribution what they have heretofore considered as their vested right.

Only a careful consideration of all the factors involved, and more wisdom than is usually displayed in adjusting conflicting interests, can prevent something of an *impasse* and a good deal of bitterness. This phase of the problem is worthy of your thought. It does not mean, however, any revolutionary changes in the accepted policy of taking care of the indigent.

I would therefore submit for your consideration in this particular problem, 3 points:

(1) Are the Hospitals and Out-Patient Departments for the care of the indigent, being run as efficiently as is possible?

(2) What changes should be made in the traditional non-payment of the doctors who are rendering this service?

(3) Is the service rendered being given economically, with a view to the earliest possible return of the sick individual to health, under circumstances not repugnant to humanitarian instincts; but, on the other hand, not dictated by what might be called emotionialism, requiring an outlay of expenditure resulting in a burden being placed on the able-bodied which it is unfair for them to meet?

In attacking the main part of our problem—that having to do with our middle economic group—I would beg to call to your attention certain factors which I think are given too little consideration in the "Wilbur Report" and which, if made the subject of intensive study, might do much toward solving the problem.

In several places the *Report* alludes to the fact that the quality of service which is capable of being rendered by members of the medical profession, varies with individuals. Such terms as "those less qualified to give medical service" appear in different connections. There is no clearcut statement, however, to the effect that this is a serious part of the problem, and it seems to be a situation a frank discussion of which is not considered to be in good taste. In fact, it is stated candidly by leaders of organized medicine that the medical profession, as a body, should cover up the shortcomings of its members because it would further shake public confidence in all doctors which already is below a desirable standard. This does not seem either a constructive or tenable position. That individuals in all classes of society are differently blessed with natural ability and acquired training is an everyday accepted observation. Why the medical profession should be considered an exception is not clear, and as a matter of fact, every man in the profession, whether among the leaders or among the followers, can testify to the contrary from his personal experience.

The wiser plan would be for the profession to frankly and openly acknowledge it, and bend its efforts toward the correction of any evils arising from it. This correction, in my opinion, should take 2 forms: Is everything being done to train all members of the medical profession so that they may reach their maximum efficiency? Decidedly not. The report of the Commission on Medical Education should be studied in conjunction with the Report of the Committee on the Costs of Medical Care. The profession as a whole, and the medical educators in particular, should be aroused to the knowledge that many opportunities for medical education are being neglected.

Time will not permit a full discussion of this phase of the situation. I would, however, call your attention to the present method which makes too little provision for formal education of the doctor during and especially after his internship. Because of his natural endowment, or because of favorable circumstances, he may find himself in a position to continue this education in the medical schools, the hospitals, the clinics or other places. Thus, those who are by nature most advantageously placed will be most easily able to avail themselves of opportunities to further perfect their efficiency as practitioners. The less able find it exceedingly difficult to establish the necessary relationships which will give them an opportunity to carry themselves forward to that degree of efficiency which their natural capabilities permit.

Thus, we find a very distinct line of demarcation cutting across the entire profession which we all recognize in our daily professional lives, but to which we give far less concern than we should. It is inevitable that the more highly endowed and better trained will find their greatest field of activity as private practitioners among those who are amply able

to pay for medical care: that is, our first economic group. These men, under the present régime, also render an enormous service in the municipal and private hospitals in caring for the near-indigent and the completely indigent. Their cliéntèle, however, includes to a much less degree that middle economic group with which we are particularly concerned, and as a result this latter group may fall under the care of those who have less facility and training for their work. In evaluating the *Report* it is not apparent that the "Wilbur Committee" gave consideration to this phase of the problem to any great extent, or made an effort to determine what percentage of the inadequacy of medical care should be ascribed to the fact that the service being rendered is not of standard efficiency. It is my belief that a change along lines which would give definite consideration to the educational needs of the less favored position of the profession would lead, to a very considerable degree, to improved adequacy of treatment.

It is therefore my plea that serious thought be given to developing a procedure for making educational facilities easily available to a much larger group of the doctors than now obtains. This is a subject which might well be discussed for an entire evening but for the present I must dismiss it with the simple statement that the problem is being earnestly attacked in New York City at this time and, I presume, in many other parts of the country.

The second direction in which it is necessary to move is for the profession itself to so organize that those who are less capable may be, under proper supervision and guidance, made more serviceable in the whole plan of rendering medical care. This is no new conception in so far as it applies to those who are connected with our hospitals. There exists in these organizations a gradation of personnel from top to bottom so that every individual fits into the scheme in such a way as to profit by and render the best service of which he is capable. It does not seem beyond the range of hope that a similar gradation can be made outside the hospitals. Under such a plan those who, for one reason or another, are operating on a plane below that to which their ability entitles them, will arise to a higher plane; and those who have not the ability to do so will still be utilized to their greatest efficiency.

Such a plan would result in a mutual helpfulness within the profession which is not apparent at present. That it has very great inherent difficulties cannot be denied but we are in the midst of an exceeedingly difficult situation and cannot get out of it unless we look at underlying causes and strive to move along lines of sound principle irrespective of the difficulties involved.

What then should be the position of the Medical Society of New Jersey in helping to meet the challenge now placed before the medical profession of this State and this country?

It would be a presumption on my part to attempt specifically to answer that question. It does seem to me, however, that the work of the "Committee on the Costs of Medical Care" has placed before you the definite factors that must be given your serious consideration. My view leads me to believe that the recommendations which urge upon local communities an attempt to solve their problems locally, have great value. Each community is familiar with the situation as it exists in that State. You gentlemen in New Jersey know the number of doctors available; the types of service to be rendered. You are able without outside assistance or interference to determine to what extent the service being rendered is adequate and efficient. You know whether your county society is sufficiently entrenched in leadership or can so be entrenched, to make its findings binding upon your community. You know whether hospital facilities or organizations are such that they can be entrusted with the development of a medical center idea which will give good service to the community not only within but without the hospital. You can determine whether or not the county society is fully equipped to undertake the full responsibilities of developing a program which will satisfy your own demands and those of the community so far as public and individual health are concerned. You know, or can estimate, to what extent a portion of the profession is neglected in the field of educational opportunity. You know the agencies outside of the profession that are available to help meet the challenge. We all *should* know that

there is a definite trend of thought perhaps dominating certain classes or individuals, who, sooner or later, will make the attempt to use the medical profession as its tool in getting a health service which society believes it has a right to demand. The immediate problem before New Jersey would seem to be, therefore, a serious determination as to *how far you are prepared to assume leadership,* and *how far you are willing to go in an active attempt to put into execution wise leadership.* No one has the temerity to believe that adequate medical service will be rendered to any community except through the medical profession and its allied professions. There *are* those, however, who have the temerity to state that, up to the present, the medical profession has not met its proper and full responsibility, and they are prepared to subjugate the profession to their views unless the profession proves it is more wisely powerful than these outside interests.

The challenge is clear-cut! The result is in your own hands! And, it is my belief that disaster will arise *only if* prejudice, pride of authorship, or indulgence in an antagonistic frame of mind, be allowed in States like ours—New Jersey and New York—to confuse the issue or to prevent careful consideration, deliberate study, and wise counsel, guiding our actions.

DISCUSSION OF OUR ECONOMIC PROBLEM

Elbert S. Sherman, M.D.,
Newark, N. J.

It was with considerable diffidence that I accepted the invitation of the Trustees of the State Medical Society to take part in this discussion of the Addresses of such leaders of thought on the subject of medical economics as the gentlemen who have just addressed you.

No subject, within my recollection, has provoked such continued and wide-spread discussion in medical societies and medical periodicals as the findings and proposals of the Committee on the Costs of Medical Care. On 2 points there seems to be a fair degree of unanimity: (1) opposition to any further extension of *state medicine,* including compulsory health insurance; (2) the necessity for evolving some plan or plans for the benefit of that large class of citizens who ordinarily are sufficiently independent financially to pay for their ordinary needs, including medical care, but suddenly are overwhelmed by an unexpected, unpredictable, expensive illness. There are 2 other classes in most communities, the indigent and the well-to-do. The latter, since 1929, have apparently dwindled to near the vanishing point, while the former have increased in geometric proportion. The poor we have always with us and they have always been taken care of by the community and the medical profession. Physicians have regarded their share in this work as a duty and a privilege, and often a pleasure. It is a tradition of the profession which most of us will not care to see wholly abandoned. The latter class, the rich, are able to fight their own battles.

It is doubtful whether there is as any great demand or desire on the part of the American people for any radical innovations in our present system of medical care, as the hue and cry raised by certain well-meaning individuals would indicate. However, the time is at hand, or very near, when some method of distributing the costs of medical care will have to be considered for individuals and families in the middle and lower income classes.

Some persons in every community would welcome a plan embodying this kind of protection, but it is questionable whether any large percentage would avail themselves of it if it were offered today. No plan can be successful until there is popular demand for it, and the demand can be created by education, just as the Christmas Savings Funds have taught many thousands to lay by a nest egg.

People should be trained to provide in advance for medical care, as for other necessities. By providing for their wants they develop strength and moral vigor. Dependence on others develops pauperism and moral weakness. Concerning the present system in England, a physician, who is a member of Parliament, said: "The people are being converted into loafers and hypochondriacs." There is

plenty of evidence that our system of unemployment relief, made necessary in this country by the recent depression, has had a similar demoralizing effect on many of our weaker citizens. It is probably the most serious evil resulting from these trying times.

What should be the attitude of the medical profession toward these problems? Certainly not one of indifference or opposition. As Dr. Ross has warned us, opposition will not enhance the position of medicine in public opinion.

All proposals should be received in a spirit of sympathetic coöperation. On the other hand, we must not be stampeded into the acceptance of hurriedly conceived plans or discredited communistic panaceas. In this State, New Jersey, we have recently shown our willingness to coöperate in the care of the indigent by our acceptance of the proposal of the State Emergency Relief Administration. By informed preparedness we must be ready to intelligently criticize unsound proposals and offer better alternatives. We can do this only after a thorough study of the various forms of "sickness insurance" and "state medicine" which have been tried in this and other countries. For a long time our Secretary, Dr. Morrison, has been "like a voice in the wilderness", as he has gone up and down the State urging us to do this very thing.

Many plans are now in operation or are being developed, in this country, some of which might very well be adapted to the needs and social conditions of other communities. The Suffolk County plan, which Dr. Ross has described, is a wonderful achievement. Some other plans which embody features of great merit and which should be studied are: "The Community Medical Service of Milwaukee County", the "California Plan", the "Vaughn Plan", of Detroit, the "Cleveland Public Health Council", and, the "Buffalo City Plan".

This Society should adopt certain principles or safeguards which must be met by any plan or proposal requiring the coöperation of our members. These should provide for free competition in the profession, founded on ability and reputation, and assuring a high quality of medical service.

The safeguards proposed by the Minority Group of the Committee on the Costs of Medical Care, if properly maintained, should assure the soundness of any plan. They are:

(1) It must be under the control of the medical profession, but a "Grievance Board" to settle disputes, having lay representation, is permissible and desirable.

(2) It must guarantee not only nominal, but actual, free choice of physician.

(3) It must include all, or a large majority, of the members of the County Medical Society.

(4) Funds must be administered on a non-profit basis.

(5) It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

(6) It should make adequate provision for community care of the indigent.

(7) It must be entirely separate from any plan providing for cash benefits.

(8) It must not require certification of disability by the physician treating the patient.

In the meantime, while these proposals are simmering, we can advocate and urge certain reforms and changes in our present methods. Those I have in mind are: (1) The immunization and preventive medical work now carried on in some of our larger communities by public health boards and boards of education should be turned over to the family physician, with proper remuneration. Such a plan is, I believe, in effect in Detroit. (2) Establishment of part-pay diagnostic clinics for the benefit of patients who are unable to pay regular fees, as advocated in the excellent Report on Medical Economics of the Camden County Medical Society.

The Monmouth County Medical Society has inaugurated a plan for public health service which sounds good and will be watched with interest.

In the May issue of the Journal there is a splendid paper on "The General Practitioner, His Responsibilities and Problems" by Dr. John C. McCoy, of Paterson, and, closing, I want to quote from and endorse his final paragraph: "I am not pessimistic nor anxious as to the future of scientific medicine, nor am

I disturbed as to the future of the medical practitioner adjusted to our social and economic structure; but I am not ready to trust the well-being and health of our people in the hands of the politician or the well-intending layman, to dictate the policies of 'State' or 'socialized' medicine. What will be the character of men who will enter the profession under such circumstances, and what will be the type of medical service vouchsafed our citizens, with supervision of the medical profession subject to the whims and changes of political parties? Let us have faith that the best traditions of our profession will prevail and the ideals and ethics of its individual members will be maintained, and thus assure the public of our sympathetic, conscientious and efficient medical care."

THE VALUE OF CALCIUM AS A PREOPERATIVE AGENT IN THE POSTOPERATIVE COURSE OF SURGICAL PATIENTS

Charles H. Evans, M.D.,
East Orange, N. J.

I. Review of Some of the Important Functions of Calcium and Their Uses in Medicine

The purpose of this paper is two-fold: first, to plead for a more universal realization of the importance of the psychologic and biologic preparation of surgical patients; second, to present a preliminary report on the routine use of calcium in preoperative preparation.

Surgical journals are overflowing with articles dealing with modifications in older methods of surgery, new surgical procedures, refinements of technic, asepsis, antisepsis, and various methods of producing surgical anesthesia. These articles are partial evidence of the constant effort surgeons are making to secure better results. Research and study never end. Unfortunately, most of the research and clinical observations are limited to certain aspects of surgery. A large majority of the studies and investigations that are made on the biochemical and psychologic responses to surgical intervention and anesthesia are reported in scientific journals which are rarely, if ever, read by the average physician or surgeon.

In order to keep pace with the advances in the art of surgery, more time and study should be given to each patient who is to be helped by the strides in the field of operative surgery. For example, progress in thyroid surgery has inspired and motivated many. These new masters of surgery have, by following a well-planned psychologic and biologic preparation, changed a dreaded surgical procedure, with attendant high mortality and morbidity, to one of comparative safety.

Progress both in the value and safety of surgery and anesthesia should be reasonably predictable in the next 10 years, not only because of advancement in surgical technic, but also by reason of the universal knowledge and appreciation of the physiochemical responses of the human body to the unavoidable damage from surgical intervention and anesthesia. There will be increasing interest in the cause and prevention of postoperative nausea, vomiting, acidosis, alkalosis, and the always feared lung and cardiovascular postoperative complications; there will be a more intelligent evaluation of the dangers that can arise from anemia, dehydration, starvation, and psychic disturbances; greater attention will be paid to the factors of pain, nervousness, and fright because of the realization that these alone may be the cause of loss of sleep and weariness, with resultant retardation of normal metabolism, healing, and repair. It will be more fully appreciated that these factors may be the sole cause of an early or late postoperative shock, and that, due to both voluntary and involuntary responses to postoperative pain, respiratory motions (more pronounced in upper abdominal cases) are limited and may decrease the vital capacity of the lungs from 20% to 80%. This reduction of vital capacity, in association with an upset in the mechanism by which normal respiration aids in the return of venous blood to the heart, is probably an important factor in the development of postoperative pulmonary and cardiovascular complications.

Despite the fact that for many years the

surgeon has used calcium, especially in the preoperative preparation of jaundiced patients, to aid in the coagulation of blood and thus reduce postoperative hemorrhage, a review of the literature does not show that it has ever been used as a routine preoperative medication.

During a 3-year internship and residency in a large and active hospital, the author noticed that many patients with jaundiced gallbladder who had received calcium before operation suffered less from postoperative pain, nausea, vomiting, and abdominal distention, and made a more uniform convalescence, than did non-jaundiced gallbladder patients who had not received calcium. This observation led to the belief that calcium was an aid toward normal postoperative recovery, a conclusion that has been verified by research, observation and trial during the last 6 months.

Calcium has many properties which make it a safe and very valuable preoperative medication. It is known that calcium is of great importance in the following processes: (1) decreases cell permeability; (2) decreases nerve and muscle irritability; (3) aids in the passage of nerve impulses from nerve to muscle through the myoneural junction; (4) stimulates normal cardiac contractions and rhythmicity; (5) increases vascular tone throughout the whole vascular system; (6) takes part in the normal coagulation of the blood; increases leukocytosis and phagocytic activity; (8) exerts an influence on the action of certain other ions and certain medications.

These properties of calcium, acting separately or in combination, have been proved by research and observation to reduce pain; lessen both voluntary and involuntary muscle spasm; aid the tissues in retaining fluids, thereby preventing dehydration; reduce hemorrhage of the capillary oozing type; reduce glycolysis and hasten glycogenesis in the liver, thereby storing glycogen for future use; increase renal activity with subsequent increased elimination of waste products and generalized edema; lessen formation of inflammatory edema; increase absorption of exudates and transudates; prevent accumulation of excessive amounts of lactic acid and subsequent loss of carbohydrate; lessen the toxicity in jaundice; and to improve liver function in hepatic insufficiency.

Bayliss, Ringer, Loeb, McClendon and others have definitely proved that the calcium decreases the permeability of the cell membrane, whereas the sodium ion has the opposite effect. This is considered, perhaps, the most important biologic property of the calcium ion.

Loeb, Mathews and others have shown that while the monovalent sodium and potassium ions increase muscle and nerve excitability, the divalent calcium and magnesium ions have the opposite effect in that they decrease nerve and muscle irritability. It is accepted that excess calcium decreases neuromuscular excitability, mechanical and electrical, and that the muscle tonicity is also diminished. In reviewing the subject, Cantarow states that these effects are produced whether the excitability of nerve or muscle was previously increased or normal, and they are exerted upon smooth and striated muscle and voluntary and autonomic nerves.

In 1894 Locke found that calcium was essential for the normal passage of the nerve impulse from nerve to muscle across the myoneural junction. Since that date many experiments and clinical observations have shown the importance of calcium in the transformation of chemical energy into muscular energy.

Ringer, in 1880, was the first to show that sodium, potassium, and calcium were essential for normal cardiac contractions, and that if the concentration of calcium were decreased, the cardiac contraction was lessened. Singer and Keith both have shown that calcium is a cardiac tonic similar to digitalis. Baetjer and McDonald have, in a recent article, also shown that calcium is necessary for normal cardiac contractions and rhythmicity.

Hooker proved conclusively in 1911 that calcium increased vascular tone; then Pearce showed that calcium therapy usually caused constriction of peripheral arterioles and capillaries and that it is essential to the vasoconstrictor action of epinephrine. Cantarow, after reviewing this property of calcium, believes that the increased vascular tone is due to the decrease in the permeability of the cells in the wall of the arterioles and capillaries.

It has been known for years that calcium was necessary for the normal coagulation of

blood. Morawitz, Fuld and Spiro believe that the action of calcium is exerted, with that of thrombokinase, upon the activation of prothrombin, converting it into thrombin which reacts with fibrinogen to form fibrin. Howel believes that calcium activates prothrombin without the intervention of thrombokinase.

Both Hamburger and Tunnicliffe have shown that either the oral, intramuscular, or intravenous administration of calcium stimulates leukocytosis, causing a high degree of phagocytic migration and activity which returns to normal when the excess of calcium is discontinued.

Salant and Washeim have proved that hypercalcemia antagonizes the cardiac depressant effect of pilocarpine and that hypocalcemia reverses the action of atropine, causing the heart rate to become slower. Cheinisse, Singer and Keith have shown that the action of calcium on the heart is very similar to that of digitalis, and that when the calcium salts are given by mouth, they increase the effects of digitalis; i. e., in the presence of an excess of calcium, the therapeutic or toxic dose of digitalis is much less than otherwise.

Behan has shown that calcium administration will in many cases of hopeless cancer not only completely alleviate the pain and render the use of narcotics unnecessary, but will also allow the patient to become more active, have a better appetite, and enjoy a feeling of well-being. He states that the calcium not only relieves the pain, but also saves these unfortunates from the devitalizing effects of increasing doses of morphine. Karrenberg has found that calcium therapy will in many cases give relief from the pain and especially the itching in the infectious, endogenous, and exogenous types of acute inflammation of the skin.

Bauer, Salter and Aub observed clinically that calcium will moderate neuromuscular excitability and relieve pain, especially that caused by spasm of smooth muscles; that a very slow intravenous administration of 20 c.c. of a 10% solution of calcium gluconate will promptly relieve the severe pain of colic caused by lead poisoning, ureteral and biliary calculi. They classify calcium as an antispasmodic. Fitzhugh, Miller, Taylor and Aub noted no significant changes either in peristalsis or intestinal muscle tone after intravenous injections of small and large doses of calcium chloride.

Haskall and Cantarow have shown that calcium gives excellent results in ulcerative colitis, where other forms of therapy have been unsuccessful. They say that the calcium relieves the spasticity of the colon, lessens the hemorrhage, and tends to relieve the pain.

Schunterman, in his studies on calcium metabolism in pneumonia patients, states that in pneumococcic lobar pneumonia with severe intoxication, the increase in irritability can be due to a reduction in the active calcium ions. He warns against giving patients with motor unrest caffeine, showing that this drug reduces the pharmacodynamic portion of the serum calcium and therefore may intensify the restlessness.

Skeleton has shown that after hemorrhage the tissues give up fluids to the blood stream in proportion to the relative permeability of the capillaries in various situations, and that the greatest relative loss occurred in the liver and the least in the skin and muscles. On the other hand, following the intravenous injection of a 2.4% solution of calcium chloride, water was abstracted from all tissues, but the greatest loss occurred in the skin, where capillary permeability is relatively low.

Since Wright, in 1891, first advocated use of calcium salts in control of hemorrhage, this medication has been used in all types of bleeding with irregular results. Investigation has shown that it is useful only in the slow capillary type of oozing, and exerts its best influence when given intramuscularly or intravenously. In other words, calcium seems to act best when there is a sudden increase in its concentration in the blood-serum.

Sollman states: "Calcium probably diminishes the permeability of the kidneys and, therefore, diuresis. The effect is not great with ordinary doses, and probably varies with conditions, e. g., the ration of calcium to other ions. The acidity of the urine is diminished, since a part of the PO_4 is deflected to the intestines."

Blum and his associates believe that the diuretic effect of calcium is due to the fundamental phenomenon of ion antagonism, where-

by it causes an increased elimination of sodium and with it water in the urine.

Increased capillary permeability is an important factor in the pathogenesis of inflammatory edema. Hamburger states that the relation of calcium, sodium and potassium ions is the determining factor in the production of edema; the calcium ions tend to make the capillaries impermeable and at the same time cause their constriction. According to Blum, calcium administration diminishes the sodium of the blood and prevents it from migrating from the blood into the inflammatory area. As the current of water follows sodium, the accumulation of fluid which ordinarily accompanies the inflammatory process is inhibited.

Januschke, in a series of experiments, showed that the inflammatory reaction produced by mustard oil was prevented by previous administration of calcium.

Gold, Rothlin and others, studying with experimental pleural effusions in animals, found that the exudate was more quickly absorbed when calcium was administered. Checking with control animals, they also found that a smaller volume (as little as 1/5) of pleural exudate was produced in those animals that had received calcium gluconate as a prophylactic measure. Blum found that peritoneal effusions were more quickly absorbed after calcium administration. Oriani and also Thone have demonstrated clinically that calcium will decrease the secretions in pulmonary conditions, such as bronchitis and pneumonia, as well as accelerate resorption of these exudates. Pelouze, Herrold and others have shown that, in many cases, calcium, besides relieving pain, decreases edema and thus hastens recovery in gonorrheal arthritis, salpingitis, and other gonococcal infections.

Calcium salts have been used in jaundice for many years. Cantarow, in his excellent book on calcium metabolism and calcium therapy, says:

"Many have reported no decrease in the coagulation time following the administration of calcium salts in jaundice. There can be no doubt that uniformly good results cannot be obtained by the use of calcium or any other agent. As stated by Wagensteen: 'The fact that deaths occur from spontaneous hemorrhage in patients with biliary obstruction, as well as after operation on such patients, indicates that the intravenous use of calcium has not solved the problem of hemorrhage in jaundice.' The same author says, however, that calcium is regarded at the present time as the most dependable agent in the protection against postoperative hemorrhage in patients with obstructive jaundice.

Too much emphasis has been laid upon the coagulation time as the sole indication of the hemorrhagic tendency in jaundice. As a matter of fact, although the clotting time may be prolonged, it is often found to be within normal limits in the presence of severe, extensive, and, at times, fatal hemorrhage. The basis for the hemorrhagic tendency in icterus is not known. It can be attributed to no factor of which we have knowledge. . . . It seems that hepatic injury and hypofunction are of greater significance in this connection than is ordinarily believed, and that agents which improve hepatic function likewise cause a corresponding diminution in the hemorrhagic tendency in such cases. Schloessmann has suggested that the beneficial action of calcium may be due to its favorable influence upon liver function. Mayo emphasized the value of glucose administration in patients with hepatic insufficiency, now a recognized fact, and Raydin has reported increased coagulability in jaundice following the injection of glucose. It is the opinion of the author that increased capillary permeability is an important factor in the causation of the slow, oozing type of bleeding from incised or injured tissues in jaundice. This may represent a diminution in the availability of calcium or a direct bile salt or pigment action.

Whatever may be the underlying mechanism there can be little question of the beneficial effect of the routine preoperative use of calcium salts in obstructive jaundice."

Minot and Culter have shown, in their brilliant experiments on acute hepatic insufficiency, that dogs kept upon a high calcium intake could receive repeated large doses of carbon tetrachloride or chloroform over periods of several months without ill effects, whereas in the absence of calcium, the animals died before 2 or 3 small doses had been given. They later showed that similar dramatic effects were obtained when poisoned animals were treated with calcium. It was found in these cases that the calcium administration returned the blood sugar to normal. Minot believes that one factor in the relief afforded by calcium medication in combating the hypoglycemia of carbon tetrachloride, chloroform, or guanidine poisoning, is the hastening of glycogenesis in the liver. Cantarow in discussing this subject says that a more fundamental action of calcium, apparently brought about through the adrenalin mechanism, is to prevent the excessive accumulation of lactic acid and subsequent loss of carbohydrate.

Minot and Cutler, Kehrer and others have studied the relation between eclampsia, hepatic

insufficiency, and calcium deficiency. They report that almost immediately after intravenous calcium, there is, in many cases, immediate cessation of convulsions, relief from headache, drop in blood pressure, and improvement in eyesight. They found that the guanidine content of the blood, which was increased in every case, was not decreased by the calcium therapy, but that the blood sugar, which was low, rose to the normal level.

Dodd, Minor and Casparis found that in infants with severe alimentary intoxication, the symptoms and blood chemistry findings were similar to those seen in animals suffering from guanidine poisoning. They found, also, that in every case improvement followed calcium therapy just as it had been observed to follow the same treatment in acute hepatic insufficiency and in experimental animals with high guanidine levels in the blood.

Cantarow, more than any one else in the literature in the field, discussed the value of calcium in the preoperative routine, but he limits its use to special cases, especially those with diseases of the liver and biliary passages with or without frank jaundice. He states:

"In practically all such cases, in the presence of chronic cholecystitis and cholangeitis, there is some disturbance of liver function. Because of the chronic nature of the condition and the remarkable functional reserve and regenerative capacity of that organ, as well as the inadequacy of available methods, this functional derangement frequently cannot be detected. Whether or not hepatic hypofunction can be demonstrated, it should always be assumed that the functional reserve of the liver is diminished and may be incapable of compensating for the added strain of prolonged operative procedure, especially if performed under ether or chloroform anesthesia."

In this section the author has presented the psychologic factors in the preoperative care of patients, the major functions of calcium, and a review of the literature on the therapeutic value of calcium administration. In a next section, he will discuss the routine use of calcium combined with other factors vital in the preoperative preparation of all surgical patients, and will present a series of cases showing the results that can be obtained through a careful consideration of the factors involved.

II. The Routine Followed and the Results Obtained in a Series of Cases

The following preoperative and postoperative procedures were adopted:

First: After the necessity for operation is accepted and appreciated, patients are assured that by following instructions and preparing for their operation, they can help in minimizing postoperative pain, nausea, vomiting, abdominal distention, and prolonged convalescence. Every effort is made to place patients in the best possible psychologic state for the coming event. Each adult patient is then placed on a routine and given the following instructions:

(1) Eat a sufficient amount of good plain food.

(2) Do not eat any fried or highly seasoned food. Do not eat meat more than once daily.

(3) Drink at least 1 glass of milk with each meal.

(4) Do not drink any intoxicating or stimulating drinks.

(5) Brush the teeth after each meal and at bedtime.

(6) Wash the mouth and gargle the throat at least 4 times each day. Use hot salt water or any good antiseptic mouth wash.

(7) Take deep-breathing exercises at least 3 times each day. (Proper exercises shown each patient.)

(8) If the bowels do not move every 24 hours, take a mild laxative. Do not take any form of laxative within 24 hours of operation.

(9) Try to sleep at least 9 hours each night.

Second: Beginning on the morning of the third day before operation, each adult patient, in addition to the above routine, receives the following preoperative medication and preparation:

(1) Sufficient calcium so that there will be a slight hypercalcemia at the time of operation; 3 gm. calcium gluconate by mouth immediately after each meal. On the night before operation, 10 c.c. of a sterile 10% solution of calcium gluconate are given intramuscularly. (The desired amount of hypercal-

cemia can be obtained by giving calcium gluconate by mouth and intramuscularly. When given by mouth, it should be taken just after meals so as not to exert a laxative effect. Blood serum calcium reaches its maximum value within 4 hours after oral administration and within 1 hour after intramuscular injection. The author used the intravenous route in the first few cases but found that the intramuscular route gave the desired results.)

(2) Sufficient alkali so that the urine will be slightly alkaline on the morning of operation. About 2 drams of pure citrocarbonate is given in half a glass of water 2 hours after meals and on the morning of operation.

(3) Each day, 6 glasses of orange juice with 3 teaspoonfuls of sugar in each glass (half orange juice and half water).

(4) Each day, 4-6 pieces (2-3 oz.) of pure stick candy.

(5) A plain soapsuds enema on the evening before operation. No cathartic is given the night before operation and no enema on the morning of operation.

(6) The field of operation is prepared the evening before operation.

(7) At bedtime on the night before operation, 1½ gr. luminol is given by mouth. Each patient is allowed to sleep as long as possible on the morning of operation.

(8) Three-quarters of an hour before the operation each patient receives ⅛-¼ gr. morphine sulphate intramuscularly.

Third: After operation each adult patient receives the following postoperative routine unless there is some definite contra-indication:

(1) As soon as the patient is returned to his bed, a retention enema of 500-800 c.c. of tap water is given.

(2) Intramuscularly, 10 c.c. of a 10% sterile solution of calcium gluconate are given as soon as patient begins to react from the anesthesia.

(3) Each patient, after he has begun to react, is placed in a slight Fowler position. After several hours, this position is increased and the knees are raised to prevent slipping down in bed, as this distorts the chest and interferes with normal breathing.

(4) No abdominal binders or tight abdominal dressings are used. When possible, only light dressings with narrow strips of adhesive are put on, thus allowing a more normal respiratory excursion.

(5) Fluids, if desired, are given immediately after operation; tap water during the first 4 hours, then weak tea, weak coffee, etc. Fluids are more or less forced from the beginning, and nausea or vomiting are not considered contra-indications.

(6) Each patient is turned on the side every 3-4 hours. If there is mucus in the throat or mouth, the patient is encouraged to clear the throat and spit out any material that can be brought up.

(7) Every patient, especially during the first 4-6 days, is made to take a series of deep breaths 3-4 times a day.

(8) During the first 3-5 days, especially in upper abdominal operations, a sufficient amount of morphine sulphate is given intramuscularly to prevent any sharp pain, restlessness, or fear. The dose varies with both individual and operation.

(9) If there is any distention, a small rectal tube is used. Such drugs as surgical pituitrin and the so-called "gas-enemas" are never used. The bowel is put at rest and not further irritated.

(10) No enemas or cathartics are given until the third or fourth day after operation. Then only mild cathartics and small soapsuds enemas are used.

(11) Patients are catheterized if they do not void within 12 hours after operation. They are then catheterized every 8 hours until they void voluntarily.

(12) Patients are encouraged to sleep as much as possible and are never awakened for medication, dressings, or any other reason.

(13) As long as patients are doing well, dressings are not changed except to remove drains and sutures.

(14) Each patient is left alone and is not allowed to be excited. Undesirable visitors are kept away, and for the first few days only the immediate family are allowed in.

In the series of 24 patients operated on with the above preoperative and postoperative procedures, there were 6 gallbladder operations, 3 of the obese and 3 of the emaciated type; 3 were over 55 years of age. One had a cysto-

cele repaired at the same time, while another had an ovarian cyst removed through a separate abdominal incision. There was no shock or hemorrhage in any case. The highest temperature recorded was 101° and the next highest was 100°. There was no nausea or vomiting in any case after the first 24 hours, while 3 patients were nauseated only for several hours and did not vomit after reacting from the anesthetic. There was no abdominal distention and no sustained elevation of pulse or perspiration. No severe postoperative pain occurred, while 2 patients remained entirely free from pain. Each patient remained moist, enjoyed fluids from the first day, and solid food by the third day.

One case was a second cesarean section performed at term on a patient in excellent health except that she was on a restricted diet because of diabetes. The highest temperature was 99°. There was no severe pain, no nausea or vomiting after she had reacted, no dehydration, and no distention. She enjoyed fluids from the beginning, ate on the second day, and was discharged on the thirteenth.

There were 3 simple appendectomies and in no case was the appendix ruptured. There was no nausea or vomiting in one case, and only slight nausea and vomiting while the other 2 patients were reacting from the anesthetic. The highest temperature recorded was 100.4° once and the next was 100.2°. There was no appreciable pain and no abdominal distention. Each enjoyed fluids following the operation and ate a small piece of toast the day after operation.

One case was a subacute appendix in a 4 months' pregnancy. This was a difficult operation with a retrocecal retroperitoneal appendix; the posterior peritoneal wall had to be opened to reach the appendix. Toward the end of the operation, the patient was taken with a convulsive attack which started in the head and spread quickly to the whole body. During the convulsions, the patient was breathing with difficulty and was in a profuse sweat. The peritoneum was closed between the convulsive seizures. After about 8 minutes, the patient became quiet and did not have another attack. Following operation, she continued to perspire profusely; temperature, pulse and respiration rose to 103°, 130, and 40, respectively, and she was slightly irrational. Nothing could be found on physical examination to account for the acute upset. The internist who saw the case stated that the occasional râle heard in the base of the right lung could not account for the condition. The next day the patient was rational, and except for being frightened and excited, was in good condition. The temperature, pulse and respiration were 98°, 98, and 26. The negative past history, except excess smoking and drinking, the negative findings on physical examination, and the quick return to normal, tend to place this as an ether convulsion which is known to occur toward the end of an ether anesthetic in those rare individuals who are hypersensitive to ether. This case was important in that it was the only case in which there was any significant elevation in temperature, pulse or respiration. It is especially interesting because during the few hours that the patient was critically sick there was no nausea, no vomiting, and no abdominal distention. The fluids lost by the profuse perspiration were balanced by the large amount of fluid taken, with enjoyment, by mouth. The patient made an uneventful recovery, ate on the third day, and was discharged on the eleventh.

The thirteenth and fourteenth were gynecologic cases: the former was an amputation of the cervix and resection of adhesions binding an ovary to the posterior pelvic wall. There was no nausea or vomiting after the first 12 hours, no abdominal distention, and no severe pain. The highest temperature was 99°. Fluids were enjoyed from the first; solid food was given on the day after operation; and the patient was discharged on the eleventh day. The second patient received a perineal repair for rectovaginal fistula, dilatation and curettage, cauterization of the cervix, appendectomy, resection of an ovary, suspension of uterus and plastic for sterilization. The highest temperature was 100°. There was no nausea or vomiting after the first day, no abdominal distention, no dehydration, and the patient said that while in the hospital she did not suffer any pain sufficient to keep her from eating or sleeping. Fluids were given the first day and food on the next day. She was dis-

charged on the sixteenth day, after all wounds had healed by primary union.

The next case was dilatation of cervix, curettage, cauterization of cervix, appendectomy, oöphorectomy, and suspension of the uterus. This case was important in that the patient was a bleeder, a fact which had been overlooked. I had previously treated her in my office and had cauterized her cervix without any noticeable bleeding. She has had one child and one possible miscarriage. At times she has an excessive loss of blood with clot formation during the first 2 days of a normal 5-day period. She also states that she had a hemorrhage following a tooth extraction. This case is important in the present study because, although the patient bled profusely (constant oozing) during the intra-abdominal operation and for several hours after operation, she was not nauseated, did not vomit, and because of a desire for fluids and a willingness to take them, did not become dehydrated. The highest temperature was 100° and the pulse never went above 100. Liquids were given on the first day and the patient ate candy and semi-solid food on the day after operation. She suffered scarcely any pain, was not distended, and was discharged on the eleventh day after enjoying her stay in the hospital. Following operation, she was given 800 c.c. of 5% glucose intravenously and about 50 c.c. of her own blood was withdrawn and injected intramuscularly.

The fifteenth case was one with large bilateral tubo-ovarian abscesses of gonorrheal origin, which were removed *in toto*. There was no nausea or vomiting after the first hour, no abdominal distention, and the patient said she did not suffer any pain while in the hospital. She enjoyed fluids on the first day and solid food on the third day. The highest temperature was 100°, the wound healed by primary union, and the patient was discharged on the fourteenth day in excellent condition.

The next case was one with a low-grade obstruction of the stomach and duodenum. On exploration there were found a primary carcinoma of the liver and masses of adhesions which had obstructed the duodenum. The patient came into the hospital with nausea, vomiting, and severe upper abdominal pain. Examination showed marked tenderness and a mass in the upper right abdomen. Laboratory examinations, including chemical blood and icterus index, were normal. Following operation, there was no nausea, no vomiting, no severe abdominal pain, no distention, and the highest postoperative temperature was 100°. The patient made an exceptional convalesence, enjoyed fluids on the first day, ate on the second day; her wound had healed by primary union and she was planning to go home. On the eighth day the severe pain returned, and she gradually became more toxic and died, in coma, on the nineteenth day.

There were 8 minor operations, as follows: removal of cyst from female breast; 2 hemorrhoidectomies; tonsillectomy and cauterization of the cervix; 2 other tonsillectomies, one in a woman 64 years old; and 2 diagnostic curettages. The highest temperature in the series was 100°, there was no abdominal distention, no severe pain, and fluids and food were enjoyed from the first. It was interesting to note that the hemorrhoid and tonsil patients suffered little pain.

In the 24 consecutive cases there were no infected wounds, no stitch abscesses, no abdominal distentions, no case of dehydration, no case of acidosis, no cardiac abnormalities, no respiratory complications, and no signs of thrombosis or embolism. The only postoperative treatment given, other than the routine treatment, was the glucose infusion and subcutaneous blood injection given to the fourteenth case. There was a definite decrease in the amount of postoperative pain, restlessness, and especially nausea and vomiting after ether anesthesia. Every patient was able to take fluids within the first 12 hours and solid food within the first 3 days after operation. The highest recorded temperatures were 103° once (in patient with ether convulsion), 101+ twice, 101 3 times, and 100+ 12 times. The average temperature was 98.75,* the average pulse rate was 86.3, and the average respiratory rate was 20.4. The average time in the

*In the hospital the rectal temperature is taken, if practical, during the first few days, then, if the patient is doing well, the mouth temperature is recorded. In this series all temperatures are given in the terms of the mouth temperature.

hospital was 8.6 days for all cases and 12.8 days for the abdominal cases.

My observations in this limited number of cases indicate that routine preoperative calcium therapy, when properly used in combination with alkalies and other preoperative measures, will decrease postoperative pain, nervousness, and muscular spasm, as well as postoperative and postanesthetic acidosis, nausea, vomiting, dehydration, and other possible complications. There were no contra-indications noted, either in the literature or by observing the individual patient, except the fact that, although the urinary secretion was normal or slightly increased, the ability to void was slightly decreased.

This preliminary report is based upon the clinical results of the cases studied. At the present time a more extensive study is being carried out and will be reported at a later date. Besides the clinical observations, a thorough study will be made of the blood and urine and vital capacity changes, before preparation, before operation and anesthesia, after operation and anesthesia, and during convalescence. It is hoped that this study will also give more light on ways of lessening or perhaps preventing postoperative pulmonary complications, thrombosis, and embolism.

THE SALICYLATES IN RHEUMATIC FEVER

Harlow Brooks, M.D.,

From the Fourth Medical Service, Bellevue Hospital,

New York, N. Y.

There is still considerable discussion in the profession as to the use of the salicylates in rheumatic fever. There appears, however, to be little dissension on the part of those who suffer from rheumatic pains as to the utility of the salicylates in relief of suffering, and I find that members of the profession themselves, when suffering from rheumatic pains, are quite as liberal in their appeal to the salicylates as is the lay public.

The universality of use of the salicylates in rheumatic pain is wide-spread. Probably no other group of standard drugs, unless it be the laxatives, is in such wide general lay use, as witness the advertisements everywhere and the constantly increasing new forms and preparations put out even by the most conservative and ethical drug manufacturers. It is almost an axiom that where a drug is so generally employed by those who suffer from the disease, it must have a considerable value, for after all the real judge of the efficiency and efficacy of any method of treatment is the public on which it is practiced.

That the drug, with one group exception, has little serious toxic action, and that its benefits must be far greater than its bad effects is also attested by its popularity. There is probably no other drug so generally in use by the public (unless we again except the laxatives) and from which we see so little harm even from its wide and unintelligent usage.

Still, in the medical profession, there is a question as to the salicylates, probably mostly because we do not as yet understand their complete action. Surely no clinician can question the comfort which the drug conveys, in suitable cases, and when given in a proper way, and, I think I may add from my own experience, when directed by one entirely familiar with its capacities.

Like most of the more valuable drugs, the salicylates have been employed for generations in one form or another, just how long, no one knows. About 30 years ago I went to the upper waters of the Montreal River, above Fort Metachewan, to visit a famous canoe-maker, a very old medicine-man of the Ojibway Medewin. Learning that I too was a medicine man, we began talking medicine after the manner of the kind. While he was engaged on a beautiful canoe, I noted that he was also carefully tending a fire on which he was burning the fragrant northern willow. When I asked its purpose, he told me that of the ash of the willow mingled with the juice of the tree, he was able to prepare a remedy of great usefulness in the cure of rheumatism. I doubt if my old friend was seriously worried as to whether the action of his salicylate thus produced was allergic; at least, he knew that it gave relief from rheumatic pains. His knowl-

edge of the efficacy of the salicylates had been derived from his ancestors, and he looked askance at the sodium salicylate which I left with him, telling him that it was derived from the very material he was preparing, and that it also was useful in relief of rheumatism.

It is curious that we as a profession are likely to question until we are able to explain on a scientific basis; yet most of our efficient drugs have been first empirically discovered and used, and for the scientific manner of action we have had to wait often many generations. Witness quinine, digitalis, mercury, ipecac; and among the drugs still widely employed but as yet unexplained are the iodides and salicylates. Even iron, long empirically used, has but recently received its scientific justification and baptism.

The fact that so many salicylates are in vogue in the profession, so many forms are employed and in so many combinations, explains the well understood fact that there is a wide individual reaction toward the drug. Some patients react best to the familiar salt with sodium, which is, I think, by far the most favored form. Salicin alone is favored by some; aspirin, tolysin, salol and the salts with quinine, all have their advocates; and nearly all exhibit some peculiarity of reaction or variation of toleration which justifies their addition to our armamentarium.

It is also my observation that in most instances when any form of the drug is long continued, it loses, to a greater or lesser degree, its particular efficiency in that patient; and the maximum effect is usually best preserved by changing the type or form of the drug at frequent intervals. There are, however, definitely many persons who will respond satisfactorily to one preparation of the drug and remain negative to others. This is probably one chief reason for the many forms of the drug which are in use and at least in part the reason why different physicians select different preparations of the drug. There is apparently no means of detecting which is more efficacious in any patient except by pure therapeutic experimentation, a method of study just as valuable and scientific in human clinical studies as though on the lower animals and in the pharmacologic laboratory. Happily, there is now again a tendency in the profession to accept such therapeutic studies as a scientific justification for the use of any curative method.

The manner of administration is also a matter of great importance, and only the clinician who has the whole range of possibilities in this respect also at his command is fully competent in the use of the drug.

As a rule the salicylates are given by mouth, and commonly the dosage is divided so that maximum doses are thrown precipitately on the gastro-intestinal tract. One of the worst and most obvious disadvantages of the drug is its irritant effect produced when given by mouth. As a rule, given in this manner, the drug is best tolerated when given in solution, and fortunately the efficient sodium salt of salicylic acid is highly soluble and may be given in almost any convenient menstruum, but usually in alkaline preparations which are best borne by the stomach, though there are patients who do best in all ways when the drug is given in acid form. Again many choose to give the acid form of the drug in association with alkalis, as salicylic acid in powder form with sodium bicarbonate, the transference of the base taking place in the fluids of the stomach and intestinal tract, the highly absorbable form of the drug being thus liberated in a nascent state. Given thus, the drug is preferably given in divided doses repeated several times daily, and because of its irritant nature, it is commonly found advantageous to give it with food of some sort, hence it is usual to give it 3 times daily and with food.

Except for the local irritation sometimes noted when continued for a long time, the salicylates produce no other and no more disagreeable symptoms when given by mouth than when administered otherwise.

Persons who tolerate its gastric administration well, may be given large doses, 30-50 gr. of sodium salicylate, preferably in solution.

In our opinion, the most constantly effective avenue of administration is per rectum. Aspirin, salol, tolysin, the quinine salts, all may be well given in suppositories to be introduced into the rectum, 1, 2 or 3 times within 24 hours. They may, however, be also given in suspension or in solution, as a rule even

more satisfactorily. The dose given *per rectum* need rarely be repeated over once or twice during the 24 hours, for it may thus be given in large amounts, the absorption is relatively slow and the effects sufficiently prolonged. Two vehicles are in common usage for this purpose on the fourth medical service of Bellevue Hospital. The more common is introduction through a catheter and syringe, introduced 6-8 in. up from the anus, in 2 or 3 oz. milk or in 2-4 oz. warm water, to which a small amount of starch had been added to render the preparation non-irritating and demulcent.

In ordinary cases we give from 120 to 180 gr. of sodium salicylate in this manner at bed time, and if need be, the dose may be repeated after 12 hours or more often where a powerful effect is indicated. The rectum should be first washed clean with some bland solution. There are no contra-indications to this manner of administration except possible discomfort, local disease or esthetic reasons.

Large doses so introduced may cause any or all of the symptoms and signs of salicylic acid poisoning, but they are much less apt to do so than when any other manner of maximum dosage is practiced. Gastro-intestinal irritation is commonly slight indeed. The absorption of the drug by rectum is slower than when given by mouth, and the relief less rapid, but the effect is more prolonged and the comfort conveyed more lasting.

Vaginal suppositories containing the salicylates are occasionally employed satisfactorily, aspirin being the drug of choice when this method of administration is used. Intramuscular administration is not popular with either patient or physician because of the local irritation which almost always follows, but it may be well borne by some patients. Subcutaneous injections are even more irritating, as a rule, and they are rarely used.

When the cost is of no particular consideration, intravenous administration is popular with many physicians. When this method is elected, the physician must be certain of his preparation, especially that it is sterile, sufficiently diluted, that the dosage is accurate, and that there is no anaphylactic or other personal idiosyncracy to this method. There can be no question but that intravenous administration effects the quickest results, but the effects are more evanescent, and, while the benefits appear within a few minutes, they also begin to recede within an hour or so. It is a poor way to continue treatment, but it is often a satisfactory way to begin it because of its promptitude. Associated with this method, however, are all the dangers that go with intravenous medication of any kind, thrombosis, embolism and the like; but at least one knows precisely the amount of drug taken, that it is taken, and control and observation of the patient is at the maximum. The relief of pain often afforded by giving salicylate in this manner is also as prompt as by giving of morphine. A high degree of technic is necessary, however, for leakage about the sheath of a vein is painful and often necrosis and slough may follow.

The local application of oil of Gaultheria is still practiced by a good many clinicians, but, I think, with decreasing popularity. In my experience the absorption is small and the relief of pain not great. The massage with which the application is given may give some benefit, but in so far as my personal observation goes, dermal application of this or any other form of salicylate is mostly without effect. The important thing in the use of salicylates in rheumatic fever, is giving sufficient dosage to effect relief without the production of symptoms which cause either harm or discomfort to the patient.

There is little question but that the analgesic effects of the salicylates in this disease may be considerably augmented by the co-employment of various salts of magnesia. It is asserted that, when magnesia is combined with the salicylates, it forms a chemical combination and its effect is comparable to the combined effect of magnesium salts given with morphine. I have used these combinations sufficiently to feel that at least in a good many cases this is true, and apparently the analgesic effects of the salicylates are intensified by the magnesium and not entirely because of the mere addition of the alkali. As a result, smaller doses of salicylate appear to be equally effective with larger, the drug also appears to be better tolerated when it is given by mouth,

and it is possible that toxicity is less when so combined. Such combinations, with some of the standard salicylates, are now marketed under various trade names.

The toxic effects of the salicylates may be named in the order of their apparent importance. Gastro-intestinal irritation, nausea and vomiting appear when large doses are given, in any manner, but especially when the drug is given by stomach. The symptoms of discomfort are usually more pronounced if the drug is given in powder form. When given in solution and well diluted, it is less likely to give this maximum bad effect. Bad effects are also less marked when the acid of the salicylate is fully combined with an alkali. As already stated, this unpleasant result of the salicylates is much mitigated, and indeed in most persons practically eliminated, by giving the drug *per rectum*.

The second most frequent and most serious contra-indication to use of salicylates is production of tinnitus and vertigo. It is most pronounced when large doses are given intravenously, but it may occur in any form of administration. Both these disagreeable symptoms are diminished by giving with the salicylate the bromides, in my observation. Barbital also relieves this effect in some patients. Opium in some form is also occasionally necessary for prevention of this symptom, but not frequently so.

Dermatitis is not an infrequent toxic effect of the salicylates. It appears mostly in certain sensitive individuals and usually after the drug has been taken for some time. The rash produced itches severely, it resembles at times somewhat closely the rash produced by bromides, and it is occasionally urticarial in character, associated with marked pruritus and edema. Marked edema of the subcutaneous tissues may take place, the eyes swell and the conjunctivae become reddened. The rash may simulate that of scarlet fever. It may be almost punctate in character. It is also occasionally hemorrhagic. It is usually associated with some gastro-intestinal irritation, nausea, and, occasionally, slight fever or leukocytosis. The urine becomes highly colored, concentrated and urates appear in abundance. A true exfoliative dermatitis may be developed. Usually, when once the rash appears, complete abandonment of use of the drug is compelled. Occasionally the rash may persist for several weeks but ordinarily it promptly subsides with cessation of the drug. It is usually mitigated or prevented by the use of adrenalin. Once the rash has appeared, the patient seems to be sensitized to all forms of the salicylate, though in certain cases only certain forms of the drug appear to produce rash primarily. The salts with quinine appear to be particularly culpable in this respect. Occasionally the dermatitis is unrelieved by intramuscular injections of adrenalin, and it may persist for a long time. In such cases the drug is dangerous and must be discontinued.

Therapeutic Effects of the Salicylates in Rheumatic Fever

The most striking therapeutic effect of the salicylates in rheumatic fever is in relief of the pain. This relief appears to be equal both as regards the pain in the involved articulations and as to the myalgias and the tenosynovitis of the disease. As a rule, relief begins almost immediately after intravenous administrations, and though delayed somewhat longer when the drug is given by mouth or rectum, its effect is eventually quite as profound. The relief is as definite and positive as from opiates in most cases, and entirely unaccompanied by disagreeable symptoms.

Occasionally, full relief from pain requires large doses, but as a rule the degree of benefit is proportionate to the dosage. It occasionally appears in maximum degree when but small doses are given, indicating some specific action on the disease, the nature of which has not yet been shown. Nearly all patients are relieved to some degree, most of them markedly and definitely. So striking is the relief that observant patients almost invariably attribute the benefit to the drug and not to some other cause. With a dropping of the drug, pain usually reappears and most patients require the drug constantly throughout the attack.

Fever, when present, is usually but not always diminished, but relief from pain is altogether out of proportion to the degree of fever depression in most instances, and in some the drug in sufficient amount to effect a satisfac-

tory analgesia absolutely fails to affect the fever present.

Effects on arthritis. Usually, with diminution of pain goes a reduction in the evidences of inflammation about and in the involved articulation. Redness decreases, the heat of the joint becomes lessened and swelling diminished. The tenderness is markedly decreased, and movements of the joint, either voluntary or by the attendant, become much relieved. The change in appearance of the involved articulation is usually quite as striking as is the relief of pain. It is rare, however, that all evidences of arthritis disappear, and new joints may become evident even under the full effects of the drug, but they never compare in functional crippling or in pain with the joints seen in the height of the disease without the drug.

Well established rheumatic nodules are apparently little, if at all affected, but their tenderness is almost invariably greatly relieved. In tenosynovitis and myalgia, the swollen and occasionally edematous tissues usually subside, and the patient's appearance shows a standstill of the disease.

As a rule, pleurisy and pericarditis complications show from diminution to full disappearance of the pain, but where fluid is present, it is doubtful if a decrease in the amount is caused, and the physical signs, except for pain, usually remain unchanged. I have seen both pleurisy and pericarditis, and probably rheumatic peritonitis also, develop when the patient was in complete comfort under the effects of full doses of the salicylates.

There may be some deterrent or curative effect on endocarditis and myocarditis under the use of the salicylates, but I regret to say that in my experience it does not have any certainly beneficial effect on these complications, either in their prevention, relief or cure. It may exert, as some believe, a prophylactic benefit, but this is a matter incapable of clinical demonstration. The same is also true as regards iritis and meningitis occurring in patients with rheumatic fever.

A much more optimistic opinion appears to be justified, however, as regards prophylaxis in rheumatic fever. Almost every sufferer from recurrent attacks of rheumatism learns to recognize and dread the onset of attacks, and many of these testify to the marked prophylactic efficacy of the salicylates when promptly administered before the attack has become fully established. I am convinced that this is one of the most striking evidences of the specific effect of the drug in this disease.

When attacks are usually introduced by a preliminary pharyngitis or tonsillitis, often the local administration of powdered aspirin or sodium salicylate will abort the apparently impending attack. It is a fact that the lay use of the drug is largely in such instances, and when the patient has been unable to procure the drug, he is very likely to attribute the attack to his failure promptly to take a protective dose. I am fully persuaded of the prophylactic benefits of the drug as I am as to its analgesic effects in outspoken attacks.

There is a popular impression among the laity, that the salicylates act as heart poisons, especially aspirin or acetylsalicylic acid. Long experience has convinced me that this idea has no basis on good clinical observation or, indeed, that it is pharmacologically correct when applied to therapeutic dosage, even such large doses as we are accustomed to give at Bellevue.

It is well recognized that one of the most striking signs of rheumatic fever is the early appearance of a severe secondary anemia. We have, during the past few months, been deeply interested in a study of this anemia, its nature, causes, prevention or cure and it is natural that the question should arise as to the possible effects of the salicylates in its production. We are convinced that it is an evidence and part of the disease, and that it is not caused by administration of salicylates, for the reason that most patients entering the hospital with the disease are already profoundly anemic. In so far as we have been able to discover, the salicylates have no beneficial effects in relief of the anemia, except as they may act in improving appetite and in the general relief given. Furthermore, we are almost convinced that the salicylates do cause an increase in the leukocytosis which is commonly present in greater or lesser degree in the disease.

Thus, in so far as our studies have gone, we are convinced that we have, in the large

group of the salicylates, a drug of tremendous value in treatment of patients with rheumatic fever. It gives alone more relief from the most agonizing symptom of the disease—pain—than all other measures put together. In some respects its action suggests a specific adaptation to the disease factor, particularly as regards prophylactic treatment. It does not prevent complications of the disease, nor are we persuaded that it materially shortens the course or modifies prognosis. It probably has no effect on the anemia. The effects produced depend to a large degree on the efficiency with which it is given, and probably the time of its exhibition may also be of importance. The drug has few unfavorable effects on the course of the patient, and given properly, by a skilled clinician, it is entirely without danger. It does not affect the heart unfavorably.

PUTTING ON WEIGHT WITH INSULIN

George Ginsberg, M.D.,
Hoboken, N. J.

Insulin was first used in the treatment of malnutrition and underweight by Pitfield, of Germantown, Pa., in 1923. Observing the rapid gain in weight produced by insulin in diabetic patients, he determined to try its effect on non-diabetics. He selected 2 infants, aged 4 and 5 months respectively, both suffering from severe malnutrition, and each was given 1 unit daily, subcutaneously, along with the 10 o'clock bottle feeding. One child gained 16 oz. in 16 days; the other 16 oz. in 7 days.

In 1924, Marriott, of St. Louis, also began to use insulin in infantile malnutrition, giving 15 units combined with 100 c.c. glucose (20%) intravenously once a day. The first child thus treated gained 2 lb. in 12 days; the second 1½ lb. in 10 days.

Barbour, of Peoria, Illinois, reported in 1924 a series of 40 cases of malnutrition in children varying in age from 2 to 9 years; all malnourished and underweight from various disease conditions such as tuberculous adenitis, chronic bronchitis and sinusitis, pulmonary tuberculosis, marasmus, congenital syphilis, and hydrocephalus. In this series, satisfactory gains in weight and marked improvement occurred in 38 children. Of the 2 not improved, 1 was an idiot, and the other a patient with chronic hydrocephalus.

Following these reports, many observers in this country and in Europe tried out the insulin treatment in adults with malnutrition. The results were uniformly successful in putting on weight and improving the general condition.

The action of insulin: It is believed that insulin activates the process of carbohydrate combustion in the tissues and increases the fat formation from the carbohydrates. The question of whether increased water retention in the tissues was responsible for the gain in weight was refuted by Falta, who administered large doses of diuretics to patients fattened by insulin, but failed to produce increased water elimination and loss of weight by these drugs.

The action of insulin on the gastro-intestinal tract is interesting. In 1929, Quigley, Johnson and Solomon found that the subcutaneous injection of 10-20 units of insulin into normal human subjects produced an increase in gastric motility. This hypermotility produced by insulin was not inhibited by smoking, mild nausea, unpleasant emotions, or bodily discomfort. At the same time there was a decided sensation of hunger. Cascao and others found that insulin injections had a stimulating effect on the amount of gastric juice secreted, as well as on the concentration of the enzymes present in that juice. In 1932, Leuders and Watson found a marked increase in concentration of the pancreated enzymes in 18 patients, following insulin injections. They also found a marked improvement in the function of the entire biliary tract in these patients. Examination of the stools showed a more complete digestion and assimilation of food than had obtained before insulin was used. A Belgian observer, La Barre, has produced experimental evidence that it was primarily the low blood sugar which produced the increased muscular and secretory activity of the gastro-intestinal tract. His experiments

on animals seemed to show that when the blood sugar in the brain was low, the vagus was stimulated and the impulses were transmitted by the nerve to the gastro-intestinal tract, causing increased activity.

Diet and insulin dosage: We generally give a high carbohydrate and high fat diet of between 3500 and 4000 calories, or more if the patient desires. For example:

Breakfast	Baked apple with cream and sugar Cereal and cream and sugar Bacon or ham and eggs Cocoa or milk 2 slices toast with butter
10 a.m.	Malted milk and crackers
Noonday Meal	Stewed fruit or preserved fruit Cream soup Fried steak with mashed potatoes and gravy and creamed corn 2 slices bread and butter 1 cup cocoa with cream
3 p.m.	Malted milk and crackers
Evening Meal	Preserved fruit with syrup Spaghetti, macaroni or noodles with grated cheese 2 slices toast with butter and cream cheese Bread pudding with cream and sugar 1 cup cocoa with cream
10 p.m.	Malted milk and crackers

Insulin dosage: We generally begin with 10 units, 3 times a day, ½ to 1 hour before meals. If the appetite is not markedly improved by this dosage, we increase to 12, or even 15 units if necessary. As regards insulin reactions (hypoglycemia), we advise patients regarding the symptoms of nervousness, sweating and tremor; those treated at home or in hospital being advised to have orange juice handy; ambulatory patients carry lump sugar or chocolate candy, to be taken on appearance of any symptom of insulin reaction.

Since February 1929 we have used this treatment successfully on 10 patients, of which number 3 were treated in hospital; the others being treated at home or coming to the office for injections. Those patients able to take 3 injections a day gained weight faster than those able to take only 2. Again, to hospital patients it was safer to give larger doses and the gain in weight was faster. Our hospital patients gained an average of 6-7 lb. a week, while the ambulatory patients gained an average of 3-4 lb. Below are 2 cases reported in detail.

Case 1. H. L., female, aged 23, stenographer, had been a patient at my office for 3 or 4 months, suffering from gastroptosis and enteroptosis. She was tall, thin, 5 ft. 9 in. in height, and weighed 105 lb.; and had been on various high caloric diets but had no appetite and could not eat the food prescribed. As our first patient under this treatment, she was hospitalized, being admitted to St. Mary's Hospital, Hoboken, on February 25, 1929. She was placed on a high caloric diet of approximately 3500 calories, with insulin 7 units t.i.d., ½ hour before meals. Appetite improved markedly and she was able to retain all her food. The first week she gained 6 lb., and when discharged on March 10, after 15 days in hospital, weighed 118 lb., a gain of 13 lb. We have seen this patient at frequent intervals since she left the hospital, and she has held her gain in weight. We last saw her in September 1932 (3½ years after the insulin treatment), and her weight was 121 lb.

Case 2. Sister A. J., a Catholic Nun, aged 24, who had been suffering for a long time from chronic pyelitis and pyelonephrosis caused by general visceroptosis, with dropping of the right kidney and kinking of the right ureter. The pains in her right lower quadrant became so severe that Dr. C. B. Kelley and Dr. John O'Connor, of the surgical staff, decided an exploratory operation was necessary. A diseased appendix was removed, but the pain, although somewhat relieved, was still annoying. She was up and about soon, but her appetite was poor and she could gain no weight. Apparently, the visceroptosis was responsible for some of the pain. We began insulin, 5 weeks after removal of the appendix (May 26, 1932), giving 12 units t.i.d. with the usual high caloric diet. At that time she weighed 109 lb. (her usual weight was about 145 lb. as she was about 5 ft. 9 in. tall). Appetite improved at once. On June 1 she weighed 117 lb., on June 5, 120 lb. She was discharged from St. Mary's Hospital on that day and the insulin continued twice a day at the convent; the same diet was adhered to. On June 26 she weighed

130 lb. She continued to take insulin once or twice a day until August 1, when she weighed 139 lb. and pain in her right side had practically disappeared. Insulin was discontinued on August 1. This patient was seen again on October 1, 1932, at which time she weighed 142 lb. (a gain of 3 lb. in the last 2 months without insulin). She had practically no pain, and had not felt so well in 5 years.

Insulin seems to be a valuable agent for increasing weight of undernourished patients.

THE IMPORTANCE OF THE STUDY OF HUMAN CONSTITUTION IN THE PRACTICE OF MEDICINE

Frederick Hnat, A.B., M.D.,
Elizabeth, N. J.

In this period of modern medicine, when the programs of our Staff, County and State meetings are filled with papers based upon careful and painstaking laboratory and other technical procedures, one hesitates to present a subject with an approach from what might be called the philosophic point of view. It is a subject that is neglected daily, much to the detriment of good diagnostic practice as well as detraction from general therapeutic efficiency.

Philosophers of medicine have been for years attempting to investigate the kind of material upon which physicians are called to work. Charles Darwin once stated: "Man still bears in his bodily frame the indelible stamp of his lowly origin." And, in reality, that is a fair type of subject the average physician is asked to study when consulted.

One of the grandest generalizations formulated by modern biologic science is that of the continuity of life; that the protoplasmic activity within the body of each living being now on earth has continued without cessation from the remote beginnings of life upon our planet, and that thence until the present time no single organism has ever arisen save in the form of a bit of living protoplasm detached from a preëxisting portion; that the eternal flame of life, once kindled upon this earth has passed from organism to organism, and is still propagating, incarnated within the myriad animal and plant forms. In another sense, thus have developed all plant and animal forms (including all bacteria, vegetable and animal parasites) which have ever appeared on earth; and since no one of these can have arisen "spontaneously" but depends for its development upon a bit of living protoplasm thrown off from a previously existing organism, it follows that *all* living beings may be traced back through continuous though converging lines of life to the first beginning of *all* life—*the primordial protoplasm.*

From this "primordial protoplasm", Man has descended to the present species, *homo sapiens*, with his "disease potentialities"—the result of hereditary forces distorted by pressure of environment.

Now, when a patient first presents himself before a physician for relief of symptoms, he is in the evolutionary sense of Darwin the "up-to-the-instant" specimen both as regards the struggle for existence and the so-called phenomenon of variation of species. Also, when a physician first observes a patient, there immediately arise 3 problems; the mischievous external agent; the disease process; and man himself. So one can readily see that such a state of affairs is in the Darwinian sense a matter of the "survival of the fittest".

As regards the first problem—the mischievous external agent—it is self-evident that the influence of Pasteur still dominates modern medicine. When Pasteur opened the way to exact study of these agents of environment, 2 things happened; laboratory medicine was born and bedside diagnosis began a slow death. The multiplication of laboratory methods, and the technical simplicity of these, and, over and above all, roentgenology, have all but relegated pure clinical observation to the scrap heap. Yet we cannot conveniently carry much laboratory equipment around with us and some of us must still occasionally see a patient at a place other than the hospital or office. In another sense, most of us are attempting to place the unfortunate patient in a test tube to solve our diagnostic problems, or place him behind a fluoroscope to interpret disease, instead of taking another good look with the naked eye

at man himself, who has been distorted by this mischievous agent of environment. No wonder Osler said that every physician ought to read some Hippocrates every year, to learn how to observe his patients.

The second problem, the disease process, is of interest to us as well as to the pathologist. For our convenience in the study of constitution, disease results from the disastrous interaction between man and his environment. Disease is like a quarrel. Its manifestations are evidence of conflict between a particular set of qualities of a human being, and an equally particular set of adverse forces in the environment. These forces of environment may come from any of the 4 corners of the universe—physical violence, or chemical, bacterial, and psychologic violence; and those are the forces of Nature that we must combat from birth to death, in order that the fittest may survive.

Our last but most important problem, man himself, must be considered as a causative factor in his own affliction. He is the finished or "up-to-the-instant" specimen produced by growth and development, determined by the joint action of heredity and environment.

It is an every-day experience of the physician that patients will display varying resistance to an affliction either in endemic, epidemic or pandemic form, but these differences in resistance do not depend only on transient influences, such as exposure to cold and fatigue. They depend upon an inherent quality which renders a man less susceptible than his fellows. Also, it is a common experience to observe that often patients with the same disease look something alike. And that is the essence of this paper—to show that this quality of man, the "up-to-the-instant" specimen, should be given a great deal of consideration when we endeavor to treat him to the best of our ability.

With the growth of accurate knowledge concerning human constitution in relation to disease, we are coming to give increasing respect to that remarkable skill in diagnosis of disease possessed by many of our older doctors. Today, a strong impulse has been given to the study of human constitution in relation to disease by Drs. George Draper, J. Bryant, B. B. Bean and C. Stockard in this country. I have been especially impressed by Dr. Draper in his Constitution Clinic at the Presbyterian Hospital, New York City. Dr. Draper's aim is to express in mathematical terms the more or less vague impression of human constitution which we often have, that patients with the same disease look something alike.

What is human constitution? Dr. Draper's definition seems to serve us best here: "The term human constitution must properly connote that aggregate of hereditarial characters, influenced more or less by environment, which determines the individual's reaction, successful or unsuccessful, to the stress of environment." From this definition, one readily sees that there are 2 aspects of constitution, one which is inherited and inheritable and another which is influenced and non-inheritable. It naturally follows that we must classify patients according to their "disease potentialities". Dr. Draper has made a successful attempt at his Constitution Clinic of classifying all patients in disease groups. It has been found that if a special type of human organism was essential to the development of a given disease, then the presence of that disease became evidence at once of the special constitution of its subject. This method of classification of disease groups has been answered in a manner as unexpected as it is satisfactory.

In the poliomyelitic epidemic of 1916 it was observed that there was a great similarity among the children seriously afflicted. They were unusually large, often plump, with broad round faces, and 50% to 60% of them possessed widely spaced teeth and gave a history of having had abnormal dentition. Another striking observation showed that many of the parents of these children had unusual anthropologic markings; one was acromegalic, 2 were Frolich patterns with dark hair, fat faces, narrow shoulders, broad hips and "knock knees"; in 3 others, maxillary prognathism was marked, and although the body stature was small, the hands were large and broad and there was great physical strength. It is significant that adults with poliomyelitis were opposite in type to children affected with the same disease. They were usually brunettes, had moles and skin pigmentations, highly col-

ored cheeks and lips, finely chiseled maxillary prognathism with teeth crowded together, and were generally of a delicately made type.

Dr. Draper has contributed a great deal to the study of constitution. He has divided his study of the subject into 4 panels, the anatomic, physiologic, psychologic and immunologic. In the anatomic studies, anthropometrics, or body measurements, have been used by him especially in the study and classification of pernicious anemia, cholelithiasis, peptic ulcer, nephritis and hypertension and tuberculosis.

The study of about 300 individuals proved that the bony measurements of the disease groups are very similar. An example of similarity was shown in the instance of 3 cases of perforated gastric ulcer; their final measurements and proportions were almost superimposable.

Dr. Draper has devised systems of accurate measurements which may be used to classify several diseases by comparison with the type chart. An individual having a subcostal angle between 24° and 55°, for example, has an 80% chance of being a member of either the tuberculosis or ulcer groups (sometimes both, I have observed); between the angles 55° and 75°, he enters the nephritic hypertension or gallbladder susceptible groups; while with a subcostal angle larger than 75°, his chance of being a member of the pernicious anemia race steadily increases.

A consideration of the facial form of disease groups reveals more in our study. In a series of cases including the above disease groups, it has been found, based on mathematically proved variation, that nephritis hypertension people have a long, thin face with wide-set eyes; the tuberculosis group has an equally long thin face with narrow-set eyes; the gallbladder group has a wide round face with relatively narrow-set eyes; the pernicious anemia group has wide features with great interpupillary space and wide jaw angles; and finally the ulcer class has a face which is intermediate in every respect.

In the foregoing paragraphs I have presented facts as regards the anatomic panel in a study of human constitution. In considering the immunologic, physiologic and psychologic panels, one would also find interesting facts.

However, it is my primary concern in this paper to stress the importance of the study of human constitution, and present the anatomic panel as an example in the study of this fascinating subject.

So, in conclusion, I might state that, as practitioners, we should study our patient as a whole, or as a mind-body, not as 2 compartment parts. Besides its diagnostic value, a thorough knowledge of the individuality of the patient aids the physician in his therapeutic attack and tends to develop a most important quality of treatment—accurate individualization.

Finally, by means of a more intensive study of the human constitution, diseases may become recognized far earlier, and their progress arrested before serious inroads have been made into the patient's health—*the goal of preventive medicine.*

HYPERTENSION

Lodovico Mancusi-Ungaro, M.D., F.A.C.P.,
Newark, N. J.

There have been, and there are, many different opinions as to the causes of hypertension, and even with the enormous wealth of observations and literature on it, we are still groping in the dark. Is hypertension *per se* a pathologic entity, or are we making the same mistake our forefathers made in regard to fevers, in taking a symptom of different conditions as the disease itself? We know that hypertension is, after all, only a compensatory reaction of the organism to restore and assure the necessary amount of blood-pressure to the tissues, and so maintain a normal systemic capillary blood flow; and we know that only when this compensatory process exceeds the needs, or when it fails in its purpose, do we have the ever-changing symptomatology of the condition due to changes in different organs, which prevent them from performing their physiologic functions properly.

Opinions differ also as to what constitutes hypertension. Insurance companies put the normal limit of blood pressure at 140 to 150 mm. of mercury; many physicians will call "normal" any reading below the sum of the age plus 100; quite a few well-known clinicians claim that any reading below 170 in middle age is normal. As a safe working basis, we can consider readings constantly above 160 mm. systolic and 100 mm. diastolic, in middle age, as high.

Hypertension occurs at all ages. We find it in children and young adults; it increases in frequency with age and reaches its maximum between 45 and 65 in men and about 5 years earlier in women. As this is about the age of the involution of the male and female reproductive organs, there is possibly a direct relation between the 2 conditions.

There are some definite etiologic factors for hypertension, but they are only present in a small percentage of the cases. For the vast majority, the causes are only speculative. Recalling the most accepted ones, we should give first place to heredity. We inherit our vascular system. Since Hippocrates, overweight indivdiuals, with short necks and ruddy constitution, have been known to be very subject to apoplexy. Often, hypertensives are markedly of the plethoric type and belong to families in which history of cardiovascular diseases or cerebral hemorrhages is common.

The next important known factor is nephritis. As the functions of the kidneys are impaired, there is a retention of guanidine and other toxic products, which, even experimentally, will produce an increase in blood pressure. Of the hypertensives, 20% have some form of renal derangement.

Arteriosclerosis will produce hypertension only if the lumen of the arteries is narrowed. Otherwise, even when very marked, it will not produce it.

Obesity is a definite, important cause. More than 40% of the obese have hypertension. As a rule they are individuals who were active physically and good eaters in their youth, and who became sedentary as they aged, without curtailing their food intake. That obesity is the real cause of their hypertension is proved by the striking amelioration caused by reduction in weight.

Mental strains and worries have been, in my opinion, greatly overstressed as causes of hypertension. Of course many people with hypertension have had great troubles, but are such people more numerous among the hypertensives than among those with normal blood pressure? How many people go through life handicapped by the same conditions, without developing hypertension? There must be some inherent factor to cause a functional rise in blood pressure in some individuals and not in others.

Climate has, in my opinion, much to do with the condition. Numerous investigators have constantly found lower blood pressure in inhabitants of tropical and subtropical regions. Furthermore, many observed a reduction in it in newcomers after a certain time in such regions, and the credit has been given to the easy life. But not all people in those regions live easy lives. A few years ago I had occasion to take the blood pressure of more than 200 people living in small cities of southern Italy. They were middle-aged men and women belonging to the upper intellectual, industrial or financial classes, and as for responsibilities and mental strains, they had more than our average. Still, I found only 15 blood pressures above 150. Many of those people had marked signs of arteriosclerosis, but no hypertension. Of those who had a high reading, the highest was 180; 9 being known nephritics. After 2 months there, the blood pressures of the members of our party came down about 10 points, although we led a strenuous life. Certainly climate had something to do with this.

Products of faulty metabolism and abnormal secretions of endocrine glands have been given as causes of hypertension. The list is quite long; including increased cholesterol in the blood, retention of guanidin bases, blood peptides, lowered blood calcium, disturbances of acid bases, insulinism, hyperthyroidism, and superadrenalism.

Certain definite pathologic conditions are accompanied by hypertension: aortic regurgitation, stenosis of the isthmus of the aorta, some cases of mitral stenosis, arteriovenous aneu-

rysm, toxemia of pregnancy, conditions causing increased pressure or anemia in the brain, and tumors of suprarenal glands. Syphilis and diabetes are thought by some to cause hypertension.

Now, if we think of hypertension as a symptom, we can readily see that all these conditions are capable of producing it. They can act in 2 ways: (1) on the nervous system, stimulating the vasomotor center or the sympathetic, or causing a failure of the reflex mechanism which regulates blood pressure; or, (2) on the walls of the arteries themselves. In both ways, they first cause a spasm of the arterioles, narrowing their lumen. As a sequel, the total area of the channels of the blood stream is diminished, causing a diminished supply of blood to the tissues. To insure a normal flow, the blood pressure is raised in proportion. This condition is called functional hypertension. When it lasts for a while, it will cause degeneration in the walls of the arterioles and, later on, a generalized sclerosis of them, with diminished elasticity, greater narrowing of their lumen, and greater peripheral resistance, which in turn will affect the larger arteries in the same way. This is called fixed hypertension.

Outside of this, many other classifications of hypertension have been given. The most logical is McLester's, who divides it into: early hypertension, essential or chronic hypertension without nephritis, chronic hypertension with nephritis, malignant or fulminating hypertension. This last, which differs from the others only in degree, is thought by many to be of unquestionable renal origin.

The pathologic findings in hypertension vary greatly. In some cases little or no changes are found. As a rule, some form of nephritis, hypertrophy of the heart, especially of the left ventricle, and generalized arteriosclerosis are found. Hypertension *per se* does not cause any symptoms, as we cannot call symptoms the psychic disturbances that come to patients on being told of their condition. The symptoms come when the circulation in different organs is affected. The earliest, as a rule, are nervous symptoms. Headaches of different kinds and locations are generally the reason why the patient seeks medical advice. Fretfulness, irritability, annoyance by trifles, insomnia, loss of memory for recent events, dizziness, vertigo or actual fainting, will develop more or less in the order given. Speech disorders, mental depression, and drowsiness during the day will follow, and sometimes progress to what we call the cerebral crises of hypertension, with transient aphasias, monoplegias, paraplegias, convulsions and unconsciousness, which may last for a time, but which clear up as a rule. When retinal or aural vessels are affected, disturbances of vision and tinnitus are common.

Vasomotor disturbances are next in importance: flushing, palpitations, epistasis, cardiac pain, inability to lie on left side, fatigue and weakness after slight exercise, passing gradually into the condition called high-pressure stasis by Elliot, with dyspnea, rapid pulse, congestion of the liver and lungs, edema of the legs, and other signs of heart failure. Different gastro-intestinal symptoms may develop. Arthritic or muscular pains are common. In fact, we may get any kind of neurosis or vasomotor disturbance. In hypertension complicating nephritis, we have all the symptoms of the primary disease.

Few high readings at short intervals are not sufficient to make a diagnosis of hypertension. We all know how misleading first readings are. But even if we get them repeatedly for a reasonable length of time, we should remember that some individuals have normally high blood pressures. If high readings have been present in a person for a long time without increasing, we can assume that such pressure is normal for that person.

When we satisfy ourselves that hypertension is present, we have to try to find the cause. We should look for conditions like aortic regurgitation or arteriovenous aneurysm. We should rule out an incipient hyperthyroidism, which often causes hypertension. We should think of suprarenal tumors, if the pressure is spasmodically very high and then comes to normal.

After having made a diagnosis, the most important things to ascertain are duration and rate of progress of the condition. History helps a good deal, but we have other important signs. Retinal changes will help—nar-

rowing of the arteries, spasmodic at first, then tortuosity, increase in light reflex, and as the case progresses, papilledema, hyperemia of the disks, edema, hemorrhages, and white patches.

The heart is another valuable source of information. As hypertension lasts, it hypertrophies more and more to the left, as we can prove by percussion or radioscopy, which will also show more or less tortuosity of the aorta. Auscultation will tell much. The second aortic sound becomes more and more accentuated and its pitch increases, as the condition progresses. Many clinicians value this sign so much that they will question the presence of hypertension in its absence. Murmurs at the apex and at the aortic area will appear later. The cardiogram will give us information. As the condition lasts, we get first a left axis deviation, later the voltage of the QRS wave increases, then the T wave in lead 1 becomes inverted. Although we can get the same picture in other conditions, this cardiogram is so common in hypertension that it is called the hypertensive cardiogram.

In giving a prognosis, the fundamental pathologic cause will govern our judgment. In hyperthyroidism, in arteriovenous aneurysm, in tumors of the suprarenals, it ceases with elimination of the primary condition. In the hypertension of renal diseases, the prognosis is that of them. In malignant hypertension, it is extremely bad. In emotional hypertension, when readings show a great deviation from normal, the prognosis is very good. In essential hypertension in middle age, when the kidneys are good, arteries soft and heart in good condition, it is also very good. It becomes more and more guarded if the progress is rapid, and if signs of cardiac, renal or cerebral involvement appear. The level of the systolic pressure has a relative importance, but a great fall in it without a corresponding fall in the diastolic pressure is a bad sign, indicating failure of the left ventricle. The level of the diastolic pressure is more important. The prognosis becomes less and less favorable as it rises from 100 mm. of mercury. As a rule the condition progresses more or less slowly, sometimes up to a ripe old age, and ends generally in heart failure, cerebral hemorrhage or uremia.

Any intelligent treatment should start with prevention. Knowing as we do that heredity is an important factor, we should protect children of hypertensive families, especially those showing hemorrhagic tendencies or vasomotor irritability, from intensive mental or physical work. We should impress on young adults belonging to such families the necessity of alternating work with relaxation. When we satisfy ourselves that a patient has hypertension, we should be extra careful in telling him about his condition. Many lives have been made unhappy and useless by the careless statement of some physician. It is not a good policy to keep the information from him, but in imparting it we should use the fine judgment that makes medicine a real art. Many patients have come to me in a state bordering despair, because they had been informed elsewhere they had high blood pressure, and have left me smiling and satisfied because I have persuaded them that their condition is not so hopeless as they thought.

Hypertension *per se* does not require any treatment. Pressures below 170 do not cause degeneration in organs, and our business is not to lower blood pressure, but to make the patient comfortable. When symptoms start to give trouble, or when the compensatory process exceeds the needs of the organism, we have to use some form of treatment. In early cases practically all symptoms are of psychic origin and suggestion usually cures them. When we deal with a real essential hypertension, we have to treat such case as a problem in itself. These patients like sympathy. We have to analyze their habits, family, social and business life. We can only do it by gaining their confidence. Often we find a real or imaginary mal-adaptation. We have to correct all excesses in mental or physical work. We have to insist on rest when the life is too strenuous; we have to advise exercise when habits are sedentary. But let me emphasize that we should never burden our patients with a lot of unnecessary rules and restrictions, which will only focus their minds on their condition.

In highly nervous people, fighting against great responsibilities, we should insist in their giving some of them up. If they can afford it, a vacation, preferably in a warmer climate,

will work wonders. In a great majority of cases this will be enough to correct the condition or to render the patient less afraid and more reconciled.

In obese people we can get good results by modifying the diet so as to make them reduce slowly. As a rule their blood pressure will go down as their weight goes down. But let us remember that we cannot cure these people by starvation, so their diet should always be satisfactory. Restrictions of proteins and salts are entirely uncalled for except in nephritis, when the amount of proteins should be reduced in ratio to the blood urea.

If we have real, tangible foci of infection, we should remove them on general principles, but without expecting much from it. Many of my patients, in the course of their disease, have had their tonsils or gallbladders removed, teeth extracted, antrums washed, and they still have high blood pressure. Physical therapy is of great help. Warm baths, light, vibration baths, effervescent carbonic acid baths in different spas, will all give pleasing results. Massages, high-frequency currents, diathermy, have also been used with marked benefit. Hyperventilation of the lungs, as suggested by Rappaport, is also worth trying. Ovarian, parathyroid, liver and glandular extracts, have all been used and have their advocates. We used to read wonderful reports of results with liver extracts, but outside of the original users, none have been able to reduplicate them.

Use of drugs in hypertension is still in the experimental stage. In valuing their action, we should always remember that normally there is a great fluctuation in the level of blood pressure. Also we should keep in mind that Ayman obtained, with inert doses of dilute hydrochloric acid, the same wonderful results claimed for the most advertised drugs. Medicines can only act by diminishing the spasm of the arterioles, acting directly on their walls or on their nervous mechanism. They can also act by lowering the cardiac output, but none would want this to happen. The list of drugs is unusually long. Purgatives have been used and are still in vogue in some circles. They can only benefit by keeping the stools loose and preventing straining. We can obtain the same result, without the drawbacks of frequent purgation, by judicious addition to the diet of vegetables and fruits. Sedatives have a definite indication in nervous patients, and their use is for a time beneficial. Chloral, bromides, barbituric acid derivatives, all act more or less in the same way, and the selection of one of them is a matter of personal preference. Nitrites have numerous advocates, but useful as they are in anginal conditions, their action in lowering blood pressure is far from satisfactory. They act directly on the smooth muscle fibers of the arterioles and veins, so they act in preference on the vessels of the abdominal organs, which are rich in them. This of course has a tendency to reduce the flow of blood in the coronaries and the cerebral arteries, sometimes to a dangerously low point. Even if they reduce blood pressure, their effect lasts only for a short time. Amyl nitrite has been used as an aid in prognosis, the claim being that it is better as the diastolic pressure comes down toward 90. Iodides are worth trying. Many times they give good results even in the absence of syphilis. The purine derivatives have been much used. We cannot say much about them; they are useful in angina by effort, but not so good in hypertension. We used bismuth subnitrate extensively and thought for a while we were getting good results, but after a few months we gave it up. Benzyl benzoate, mistletoe, garlic and many other drugs are used and said to be useful. We have no experience with them. We are reading now wonderful reports of the action of watermelon seeds. Let us hope they will be confirmed. A drug that was much used and heralded, since its discovery by Pauli, was potassium sulphocyanate. But lately many unpleasant and dangerous reactions have been reported following the use of even small doses of it. The best we can say about drugs is that their action is evanescent and only valuable as a temporary measure.

As most of the symptoms of hypertension are related either to heart failure or serious renal insufficiency, we should be always on the lookout for them, and, when present, treat them as such.

In cerebral involvement we should protect patients against sudden emotions, which easily

cause cerebral hemorrhage. Bleeding is indicated in them, and many times lumbar puncture will help in the severe headaches so common.

In closing, we should remember that hypertension is at first a compensatory condition, not requiring any treatment. It becomes in time a generalized vascular disorder, affecting any part of the vascular tree. We should then be guided by the organs affected, and we should always remember that improvement in the condition is often not due to management or drugs, but to the natural remission so common in this condition.

MESENTERIC VASCULAR OCCLUSION

A. B. Abrams, M.D., F.A.C.S.,
Associate in Surgery, Beth Israel Hospital,
Newark, N. J.

Mesenteric vascular occlusion is of particular interest to the surgeon because of its gravity, its comparative rarity, the difficulty of diagnosis, and the poor results usually obtained surgically. The first case of mesenteric vascular occlusion was recognized and reported by Tiedemann in 1843, and subsequently Virchow made an extensive study of this condition, in 1847. Since then, less than 500 cases have been reported in the literature, of which more than 200 were reported in the last 10 years.

Mesenteric vascular occlusion may occur either in the artery, the vein, or both—the relative frequency being arterial, venous, and co-existent arterial and venous. Arterial occlusion may be due to either thrombosis or embolism or both, and the occlusion may be either complete or incomplete. Incomplete closure of the vessel is not nearly as serious as complete, and usually results in the origin of symptoms known as mesenteric intermittent claudication. The superior mesenteric artery being an "end" artery, it is more frequently involved and naturally more serious than when it occurs in the inferior mesenteric artery. The usual explanation for the more frequent occlusion of the superior mesenteric artery is that its diameter is nearly 3 times as great as that of the inferior, and that it arises from the aorta at a higher point; thus having an early opportunity of intercepting the embolus. The result of occlusion is a hemorrhagic infarct, and the amount of bowel involved depends entirely upon location of the occlusion.

The symptoms vary a great deal, and are at times difficult to classify and diagnose. They also vary according to whether the case is primary or secondary type appearing as a complication to some preëxisting disease.

Most cases occur between the ages of 20 and 60. It is more predominant in the male. In about 35% there is a negative past history; in the remainder, symptoms of valvular disease, arterial sclerosis, aortitis, or some infectious process elsewhere in the body, particularly infections following such surgical procedures as gastro-enterostomy, herniotomy and appendectomy. It may also follow pregnancy and parturition. A more frequent instance may be traced to exertion, particularly straining at stools, lifting of heavy weights, or even violent coughing.

The symptoms vary according to the severity, location, and size of the thrombus. Abdominal pain is sudden, very severe, cramplike, and is the most predominant symptom. It may be generalized or localized to any particular part of the abdomen. Usually at the onset you have vomiting, which, if continued, may become fecal in character. When it becomes bloody, it should be significant. If we have a bloody stool in association with the above symptoms, it should point to a positive diagnosis of vascular occlusion. Often obstipation is present, but it may be preceded by diarrhea. Abdominal distention, although it may be present early, usually occurs late in the course of the disease. There is no elevation of temperature early in the disease, and sometimes it is subnormal. We get a rise in temperature when peritonitis sets in. The pulse becomes rapid and small as the condition progresses and is accompanied by pallor and cyanosis of the skin, as one often gets in a picture of shock. If the condition is permitted to go on, pain becomes more steady, shock more severe, abdomen distended and tympanitic, and temperature and pulse pro-

gressively elevated, followed by signs of general peritonitis. The mortality rate is about 60%, and the condition is often confused with intussusception, volvulus, or some other form of mechanical obstruction; or acute pancreatitis or twisted pedicle. It may be confused with chronic gastric ulcer or duodenal ulcer or rupture of one.

The treatment, naturally, is surgical; immediate resection of the affected area, leaving a safe margin of healthy bowel, offers the best chance of recovery. Naturally the end-results depend largely upon the amount of bowel that must be resected. In a series reported by Klein, of 9 patients suffering with mesenteric occlusion, all recovered spontaneously. There are some cases on record in which, after opening the abdomen, a large segment of bowel was found to be gangrenous, and it was thought unwise to remove such a large segment; a drain was inserted then in the abdominal cavity or in the bowel, and recovery resulted. This can be explained by the fact that collateral circulation had taken place. Brenner reports recovery of patients from whom 540 cm. of gut was removed.

When the symptoms are not so severe, but the diagnosis of mesenteric embolus is suspected, or where the severe symptoms rapidly subside, the surgeon should wait, as collateral circulation may be taking place. The surgical rule should be to resect as little of the intestine as the pathologic condition permits, and in order to aid metabolism, should these patients recover, a diet rich in carbohydrates, low in fats, and easily assimilated, should be given.

The following case report is of unusual interest because the diagnosis was literally made too early—because infarction had not yet taken place at the time of operation:

White female, M. W., aged 32, came into the hospital on Oct. 13, 1932, with the following history: No recollection of any childhood diseases, but had been suffering from a rheumatic heart condition for 20 years. Last attack of rheumatic fever 3 years ago. Recently, heart had been fibrillating. About 2 weeks ago, was seized suddenly with a severe pain on left side of head, after some exertion which was caused by moving large objects. This lasted 5 days. During this time, patient received large doses of digitalis and remained in bed. No localizing signs then, and there were no Babinski, ankle clonus, increased reflexes, nor pupil signs. The condition was diagnosed as an embolus to a silent area of the brain. Feeling better for a time, she got up to go to bathroom, and while at stool was suddenly seized with a violent attack of pain in mid-abdomen, which even 2 doses of morphine, ½ gr. each, given within 15 minutes, did not relieve. Pain started at 3 p. m. Between this time and admittance to hospital, 4.45 p. m., patient vomited 2 or 3 times. On admission, temperature was normal, pulse regular at 72 (not a true indication of the rate, because she was digitalized) and respirations 22. Patient was of the asthenic type, and apparently in great distress, extremely restless, and had to be restrained. Physical examination revealed a pulsation in the neck which was not rhythmic. Face was flushed, pupils slightly dilated. Lungs revealed nothing abnormal except some moist râles at bases. Heart showed that apex beat was at anterior axillary line; a definite thrill was palpable which was timed as presystolic; and there were 2 murmurs replacing the normal sounds at apex. Rate was very irregular, and a systolic murmur was heard, rough in quality, all over heart. Whole right side of abdomen was rigid up to midline; tenderness and rebound tenderness in this region. Left side soft; no tenderness present. No masses were felt and no organs were palpable. Extremities were cold and blood pressure 136/90. Diagnosis as mesenteric vascular occlusion. Leukocytes 7100, with 78% polys; 15% lymphocytes; 3% endothelial cells. This indicated, to our minds, that some severe intra-abdominal calamity had occurred. Urine showed a slight trace of albumin, several red blood-cells and some whites. At about 11.30 p. m., a consultation was called and the possibilities were considered: mesenteric occlusion, acute pancreatitis, empyema with rupture of the gallbladder, ruptured appendix, duodenal ulcer, and volvulus. All were agreed that there was definite indication for an exploratory laparotomy, and that this was probably a mesenteric occlusion.

Patient was operated on at 2 a. m., with

the following findings: About 300 c.c. of serosanguinous fluid in abdominal cavity. Stomach and duodenum negative. Pancreas normal and gallbladder negative. Ileum slightly distended and slightly injected, but no infarcts. Pelvic organs negative and appendix obliterated. A drain was inserted and the abdomen closed.

During operation, the patient suddenly became pulseless and was given stimulants on the table. She was sutured with through-and-through silkworm-gut stitches, and went to her room in very poor condition. Because of the heart condition, only 500 c.c. glucose and saline (5%) was administered intravenously and digalen was ordered every 4 hours. Small amounts of fluid were administered by mouth. At that time her menses started. She then went on fairly comfortable, but with extreme restlessness, complaining only of some gas pains, until the next day, at which time her pulse reached 66. Meanwhile, temperature had been steadily climbing until at 1 a. m., Oct. 16, it was 101.2°. At 8.15 the next morning, dressing was changed and found saturated with a serosanguinous fluid. At 3 p. m. dressing was again saturated with the same discharge. Culture was taken, of the wound, and Staphylococcus albus was found. Soon after this, patient started vomiting a dark, green-brown, foul-smelling fluid. A Levine tube was inserted and a great quantity of similar fluid was removed. Because of the extreme restlessness, 10 gr. chloral hydrate and 20 gr. sodium bromide were given as a retention enema. She became worse, sank into a coma, and died at 2.30 a. m. on Oct. 19.

It was our opinion that the findings in the abdomen were due to a partial occlusion at the time of the operation.

Pathologic findings in cases of this type are as follows: Unfortunately we were able to do only a wound examination, so that adequate access to important viscera was not obtainable. Examination of the abdomen through the wound revealed acute injection of the serous surface of both the small and large intestines. The peritoneal cavity contained about 50 c.c. of a blood-stained fluid. On gross examination, the intestines showed no evidence of gangrene or necrosis at any point, but showed areas of ecchymosis throughout the ileum and portions of the colon. Examination of the mesentery *in situ* revealed no embolus or thrombosis visible to the naked eye. Further examination could not be made as the organs could not be removed.

The involvement of the entire intestinal tract, if based on a circulatory disturbance, would necessarily mean a disturbance in both the superior and inferior mesenteric arteries, or of a venous occlusion, in the main portal circulation. To begin with, both of these conditions are extremely rare. The latter, when present, shows an easily discernible retrograde thrombosis down through the mesentery, with involvement of all the terminal veins. Such a condition was not present here. If there had been an occlusion of both superior and inferior mesenteric vessels, the only possible result would be a complete infarction of the involved area. The only other possibility to be considered from a standpoint of vascular occlusion is involvement of the superior mesenteric artery or one of its branches. In spite of the absence of infarction, this must still be considered a possibility. Abundant collateral circulation between the superior mesenteric artery and the pancreaticoduodenal at one end, and the inferior mesenteric at the other, make it possible for a vascular occlusion without definite infarction. Occlusions at this site result usually in hemorrhagic infarcts; the involved gut first becomes markedly edematous and infiltrated, then shows suffusion of blood and hemorrhage into the wall, and later may show gangrenous changes and necrosis as the mucosa becomes completely separated from the wall. Associated with the condition is a deposition of an exudate-like substance on the peritoneum, bloody fluid in the peritoneal cavity, and a thin dirty fluid in the intestinal lumen. Involvement of small terminal branches frequently results in small areas of ulceration of the mucosa, sometimes with resulting intestinal hemorrhages. This latter condition is frequently found in the intestinal ulcerations following abdominal surgery, a state which cannot be considered in this particular case. The fact that there was found an acute injection of

the peritoneum, together with some bloody peritoneal fluid, keeps within the realm of possibility the diagnosis of partial arterial occlusion of the mesenteric vessel.

THE OTORHINOLARYNGOLOGIST: HIS WORK AND HIS PLACE IN MEDICINE

Irving Wilson Voorhees, M.S., M.D.,
New York City

Recently, a new patient called up for an appointment and explained in an apologetic tone that she had intended to come in for examination and treatment of her ears, nose and throat, but that she had been suffering from "such a cold", she had waited until it improved. This led me to ask several old patients, and also several physicians, just what they think is the field of the ear, nose and throat specialist. I was amazed to find how opinions varied. An intelligent lawyer thought that a specialist exists to take care of diseases which cannot be cured by a general practitioner. A skin specialist laughed when I told him that I could cure his cold if he would let me try; it was his serious conviction that, "Nobody can do anything for a cold, and you know it". After laboring under the apparent delusion that I had cured many sufferers from *mal de nez,* it was a shock to hear this friend's remark.

The rhinologist has been hiding his light under a bushel all these years if he has neglected to set forth his capabilities so that both the general public and general profession are not ignorant of the dimensions of this important field. It may fairly be assumed that much of the jealousy which existed in the early years of otorhinolaryngology, on the part of those who felt that this specialty encroached upon general medicine, has disappeared. If there has been an encroachment, it has not diminished but has increased with the years; for we now have a specialty within specialty so highly developed that the study of a single disease becomes the life work of one man. There is, for example, the hay-fever specialist, asthma specialist, thyroid specialist, etc.—each working on problems which seem insoluble. The truth is that no matter how narrow any field in medicine seems, it has ramifications which quickly lead the medical traveler into a blind alley out of which satisfactory egress seems well nigh impossible.

But the properly qualified specialist, in order to be useful and to get as much personal satisfaction out of his professional work as possible, must be prepared to encompass a certain definite area. Naturally, the borders cannot be sharply defined, and he will now and then be obliged to consider problems in neurology or dentistry or systemic diseases of focal origin. His limitations are, however, definite enough in some directions. For example, he ought not give intravenous injections for treatment of syphilis, or administer salicylates for the relief of rheumatism. Some say he ought to keep his hands off when thyroidectomy is under consideration, and yet his knowledge of the anatomy of the neck should be helpful where injury to or pressure upon the recurrent laryngeal nerves, or the trachea or esophagus, is of paramount importance. He is criticized for doing plastic surgery of the head and neck, but who has a better right to repair deformities of the nose? No physician can be content with the simple spraying of a nose or wiping of an ear. Problems of diagnosis must always engage his mind, and it is not strange that the urge to operate is upon him whenever he sees the direct means at hand for certain and speedy relief.

Of one thing there can be no doubt—the otorhinolaryngologist does not look with favor upon consultations asked of him in the eleventh hour, after inexperienced or unsuccessful efforts have come to an end and the patient has been drained both physically and financially—specifically, those patients from whom his predecessor gets the money and the "expert" must cure the patient. There used to be more such cases than there are now, chiefly because the patient or his friends are likely to ask for a consultation or a change in management. The economics of modern medicine make it imperative that a physician "hang on" to his patient as long as possible; for if he turns him over to a specialist, he is, he feels in

danger of losing him forever. Such things do occur, unfortunately. Why should not the *golden rule* work here as elsewhere? But human nature is the same, be it found in doctor or patient. Professional competition is stiff, and there is a further great disadvantage in that no ethical physician can carry his message to the public with an eye to increasing his practice. The public needs the doctor not only when in pain but when obviously well. For example, a woman has carried a large wart on her eyebrow for years. It has embarrassed her when, upon taking a child on her lap, he has played with the wart and asked questions only a child could think of. But no physician has ever told her that it ought to be removed, that removal is easy, and without danger. But, one day a bright young doctor moved into the neighborhood. Tactfully, he approached the wart question, which he knew must be a secret thorn in the flesh. The lady was convinced; the doctor removed the wart, and found that he promptly became better known than if he had done an appendectomy and saved a life.

That was a fortuitous circumstance. But suppose this young man, with this successful case as a nucleus, wishes to become a wart specialist. How is he going to go about it? How is the public going to find out that he has a special interest in warts? About the only way is to build up a large general practice, and tell his patients that some day he is going to limit his work to this field. If he is lucky enough to live to be 100 years old, he may do it, but the outlook is dubious even at that. Suppose he writes a paper on this subject and tries to present it before some medical society. Do you think he will get on the program, or will he be laughed off the stage of action even before he arrives? Suppose he is lucky enough to find a place to read his paper, how many of the doctors who may sit long enough to get a look at him will send him a patient? The paper is published and reprints are ordered. He broadcasts them to the medical profession, but none must be sent to the laity under penalty of medical ostracism. The profession does not even see the reprint—the efficient office secretary consigns it to the waste basket in order that the doctor shall not be "bothered with such trash".

All of this may seem trivial, but it is an exact picture of the chaotic and unreasonable state of medical practice today. To circumvent direct advertising, we have hit upon the health examination movement, which has some desirable features but has failed for the most part to attract the public to any considerable extent. It is of no great aid in bringing any specialist in contact with his public, and it is doubtful whether it has done much for the general practitioner, who is probably at fault in not supporting it as he should.

Medicine is passing through a great transition period. What the outcome will be, no man can say, but because it is unorganized, economically, the individual physician is bound to suffer, whether from state medicine or overdevelopment of the group idea as seen in the establishing of great medical centers.

At the risk of being criticized by physicians who are capable of doing many things well, but who do not call themselves "specialists" in the narrower sense, I have set down a more or less complete list of the activities of the otorhinolaryngologist, and of the nature and varieties of service which he should be able to render his community: Prevention and treatment of colds in the head, larynx and bronchi. Management of sinusitis or "gathered head", including non-surgical as well as surgical relief. Treatment of neuralgias and headaches of nasal origin. Removal of growths, polypoid and other, from the nose, with destruction of the site so that recurrence may be prevented. Enucleation of tonsils and adenoids. Removal of cysts of mouth or jaws, and tumors, benign or malign, of cheek and tongue. Repair of cleft palate and hairlip. Plastic operations about the head and face. Removal of warty or other growth. Elimination of birth marks and scars. Treatment of chronic laryngitis. Removal of growths from vocal cords. Diagnosis of hoarseness, especially that due to paralysis. Tracheotomy, especially the emergency operation. Surgical cure of peritonsillar abscess. Removal of glands in the neck for diagnostic appraisal. Thyroidectomy. Extraction of foreign bodies from air or food passages. Incision of aural

tympanic membrane for suppurative otitis. Mastoidectomy. Coöperation of neurologist or brain specialist in diagnosing tumors and abscesses of brain. Diagnosis and surgical care of meningitis when same has its origin in the sinuses or mastoids. Plastic correction of outstanding ears.

Many of these conditions are "border-line" in which the question arises as to who is most competent to care for the patients and see them through any ordeal which may arise. Only by fair-mindedness and a disposition to do what is best for the patient regardless of personal feelings, can the otorhinolaryngologist serve the public. He may, at times, find it best to step aside and allow a colleague in a conjugate specialty to seek a therapeutic solution to a given problem. It may then be his privilege to stand by and suggest some measure or test that may have been overlooked. Diplomatically done, this should give no offense, and will be welcomed by the broad-minded physician who is carrying the load of responsibility.

MEDICAL ECONOMIC PROBLEMS*

Robert Lewis McKiernan, M.D.,
New Brunswick, N. J.

According to our County Society's constitution I am enjoined to deliver a "dissertation on some philosophic or medical subject". Perhaps philosophy or some phase of it, would not be out of place in this workaday world of ours, since we are passing through one of the worst economic crises in history and it would not be out of place to remind you that the vicissitudes which have beset us during the past year are but the economic results of blind imagination. Lest we feel that we are worse off than our neighbor, we should face basic facts and readjust ourselves to conditions as they are. The natural reaction to such an economic upheaval is depression, both mental and physical; the mental being far more serious in its end-results, because of the grievances engendered by the distorted mind of a mentally ill person, which often develop a socialistic trend; and because mental ills are harder to control than physical ills.

As a result of these conditions, it follows that the medical profession has been called upon to do twice its usual amount of charity work. Since statistics prove that 80% of the cost of medical care is borne by the patient, and since the income of the patient has been greatly reduced and in some instances cut off entirely, many people who have always been treated by private physicians are forced to avail themselves of whatever free medical care is offered by private or public organizations.

The profession has been criticized in various quarters for not meeting its obligation to the public. This is largely due to a lack of proper understanding of the profession's activities, on the part of the community. Perhaps we are too prone to hide our light under a bushel, and are in a measure responsible for this lack of knowledge on the public's part. If we stop to realize that the average clinic attendance in the U. S. was, in 1921, 2,000,000, and in 1931 had increased to 4,500,000, it will surely convince the most skeptical minds that the medical needs of the poor and unemployed are being adequately met. Besides these published facts, many physicians are carrying in their offices, with no hope of remuneration, patients who formerly were able to meet their obligations.

Annual reports of hospitals generally fail to mention the valuable services rendered the hospital and charity patient by the Medical Staff. Too much of this service is taken as an accepted fact, not only by the public, but also by the lay members of the Boards of Directors. Not only should this be counted as a service to humanity, but a tremendous economic contribution to the hospital.

The public, in general, is still of the opinion that physicians are paid by hospitals for their services. We all know nothing is further from the truth but with such lack of knowledge of the profession's activities and great contribution to the health of the community, need we wonder that subsidization of medical practice has been advocated and partially carried out; as evidenced by numerous tax-sup-

*(Presidential Address, delivered December 21, 1932, to the Middlesex County Society.)

ported organizations, such as municipal health stations, County and State Sanatoriums, State and County Hospitals for the Mentally Ill, and workmen's compensation, which is more and more caring for disease rather than injury? If the public is attempting to subsidize medical practice, why does it not include in this reformation the law, industry, and banking?

The monetary contributions of private individuals and organized charities are always given great publicity, but the service rendered by the physician is accepted as a "matter of course". Perhaps the laity has given generously of time and money during this *unusual emergency,* but few realize that since time immemorial the medical profession has contributed its services freely to the health of the community, and the demands are now more than doubled. Because we have remained with our heads in the sands of science, neglecting to recognize other factors involved, we have allowed the public to dictate our policies rather than form them ourselves. Perhaps we will emerge from this crisis having learned we must recognize and evaluate the interrelationship of the business and medical worlds.

In my mind, the most simple but most effective plan for fore-stalling socialized medicine is closer coöperation among the members of the profession themselves, and an effort to create a more equal distribution of the cost of medical care between hospitals and physicians. We all realize hospitals cannot exist without physicians, nor can physicians work without hospitals.

Last but not least is the great need of more publicity to acquaint the public, and particularly lay organizations, with the medical and scientific achievements of the profession, and also the great amount of skilled service rendered to poor patients *gratis* by physicians.

The solution of this great problem, considering the best interests of both the public and the profession, must come from the profession itself.

RECENT ADVANCE IN CLINICAL STUDY OF ENDOCRINE DISTURBANCES IN WOMEN

Rita S. Finkler, M.D.,
Newark, N. J.

The study of endocrine disturbances in the human has received great impetus since 1855, when Addison described the syndrome known as Addison's disease. Since then, disturbances of other glands of internal secretions have been noted and described by great students and scientists like Graves, Froelich, Cushing and Novaks. Men and women of science are now devoting years to animal experimentation in the hope of unravelling the exact interrelation between the glands of internal secretion. The normal physiologic interdependence between these glands has been studied and demonstrated. The disturbances in the organism due to disease of one or more of them are being now extensively studied. The diagnosis and treatment of these disturbances hold the attention of the internist, neurologist, psychiatrist, student of biology, and gynecologist.

This paper is concerned with the gynecologic aspects of endocrine disturbances in women. Patients who have been subjected to special endocrine study are those suffering from primary or secondary amenorrhea, oligomenorrhea, menorrhagia, metrorrhagia, menopausal disturbances, and functional sterility. The cases reported in this paper were worked up in our gynecologic and sterility clinics. The following tests are employed in the special study of these cases:

Frank and Goldberger test on 40 c.c. of blood removed from a vein 7 to 2 days prior to the menstrual period, or taken weekly in a long-standing amenorrhea. We use the Mazer modification of the Frank test: 80 c.c. of blood are taken and the test is run in duplicates. The ovarian hormone or estrin is chemically extracted from the blood and injected in graduated doses into 2 castrated mice; vaginal smears, according to the Allen and Doisy method, are taken twice a day for 4 or 5 days;

the reaction reads minus where only leukocytes are present; plus-minus when nucleated epithelial cells and non-nucleated squamous cells are present; strongly positive when non-nucleated cornified epithelial cells alone are present; and a declining positive when cornified non-nucleated epithelial cells and some leukocytes are present. Thus we can determine not only the presence or absence of the ovarian hormone in the blood, but also a comparative amount of the same.

The second test consists in estimating the ovarian hormone content from a 24-hour specimen of urine. This test was evolved by Dr. Kurzrock, of Columbia University: 750 c.c. of urine is subjected to double distillation with ethyl acetate over a period of 24 hours; after that time the ethyl acetate is driven off and the hormone collected in 10 c.c. of olive oil; 5 castrated rats are injected with various specified amounts; each rat receives 3 injections, 12 hours apart. Smears are taken 24 hours after the last injection—for 2 days, twice a day. Interpretation of the smears is the same as in the Frank test on the blood.

The third test is for the anterior pituitary hormone or prolan. Two types of technic are used:

(1) The Zondek technic, where the anterior pituitary hormone is extracted from the morning specimen of urine and injected into 5 immature mice, like in a pregnancy test; on autopsy the ovaries are examined; in a positive case only reaction No. 1 may be expected, that is, the maturation hormone, no corpora hemorrhagia or corpora lutea should be expected in a non-pregnant woman. Dr. Frank estimates the prolan from the blood, using the sludge or residue left after extracting the ovarian hormone from the blood.

(2) We are attempting at present to employ Dr. Frank's method of estimating the ovarian hormone from the urine collected over a period of 30 days. The patient is instructed to collect all the urine passed in 3 days and bring it in a gallon container; the 3-day specimen is brought to the laboratory every 3 days until 10 or 11 specimens are submitted for analysis. Part of each specimen is extracted, and the amount of hormone noted; thus a curve can be drawn showing the amount of hormone extracted over a period of 4-5 weeks.

Obviously, the high and low points, and the exact amount of hormone excreted, vary in different women, especially the abnormal cases under our study. In spite of the great amount of work involved, the method is feasible and could be carried out with precision. When the hormone study of a given individual is completed, suitable therapy is undertaken. The following therapeutic measures are used:

(1) Thyroid medication, when indicated.

(2) X-ray stimulation of the anterior pituitary gland, and the ovaries.

(3) X-ray treatment of the thyroid gland in thyrotoxicosis.

(4) Standardized preparations of hormones derived from pregnancy urine, such as Follutein, Antuitrin "S". These hormone extracts do not act on the ovaries directly, but stimulate the pituitary gland, which activates the ovaries.

(5) Whole pregnancy urine, filtered through a Berkfeld filter and collected in sterile containers, is used by us intramuscularly in doses from 3 to 6 c.c., 3 times a week. According to Mazer, the urine of patients in the fifth month of pregnancy contains the optimum amount and combination of hormones, and is most suitable for our purpose; at that stage the urine contains a large amount of anterior pituitary-like hormone, and small quantities of placental hormones and growth hormone.

(6) Standard preparations of estrin, such as Theelin, Amniotin and Progynon.

I have selected 5 cases to show the findings, treatment and results obtained. Before I proceed with description of the cases, I want to emphasize that our tests, although time-consuming and precise, demonstrate the presence or absence of anterior pituitary hormone and the ovarian hormone only. We must not lose sight of the fact that other glands, other hormones, play an indispensable part in the normal sex functions of woman. The adrenal cortex is of paramount importance; it has a direct stimulating effect on the pituitary and thyroid glands; the thyroid, thymus and corpus luteum are also indispensable to establishment and maintainance of the menstrual periods, to fertility, gestation and normal par-

turition. The study of this intricate interrelationship is in progress now, but cannot be dwelt upon within limits of this brief presentation.

Case 1. B. R., aged 15, applied to Gynecologic Clinic for headaches, dysmenorrhea, leukorrhea, on Apr. 26, 1932. Treated for asthma in Medical Clinic. Periods always delayed 2 and 3 weeks. Weight 131½ lb. Hypertricosis on abdomen, back and extremities. Appendectomy at 12 years of age. Menses established at 12. May 7: X-ray; findings do not show definite bone destruction of the sella, but suggest some intrasellar expansion of the hypophysial gland. Blood-count irrelevant except for Eosinophilia—8% (found in asthma). Hormone estimation from a 24-hour specimen of urine: ovarian hormone, negative; prolan, negative. Filtered pregnancy urine injections started Sept. 1. Sept. 19, menstrual period. Oct. 12, period lasted 1 week, longer than usual. Nov. 3, menstrual period. Dec. 3, menstrual period.

This case illustrates genital hypofunction and the importance of readjusting the glandular imbalance in adolescence.

Case 2. B. K., aged 28. Aug. 1, 1932, applied to Gynecologic Clinic. Amenorrhea for the last 2 years, with occasional scanty blood discharge from vagina when taking Lutein tablets. Is being treated for toxic goiter in the Medical Clinic. Original B. M. R. +38. Received 4 x-ray treatments to the thyroid; B. M. R. came down to +18. Symptoms reappeared later. B. M. R. went up to +32. Received 3 more x-ray treatments. All ovarian medications have been discontinued and patient admonished not to be concerned about lack of periods. Hormone on a 24-hour specimen of urine revealed ovarian hormone, negative; prolan, negative. Patient submitted to another series of x-ray treatments to the thyroid, and since then has menstruated regularly every month. B. M. R. now is +7.

This case illustrates thyrotoxicosis, delaying normal menstruation, which was present before onset of the disease.

Case 3. Mrs. R. W., aged 28. In 1929, applied to the Sterility Clinic. Married 8 years, never conceived. Menstruates every 6, 7, or 8 weeks. Suffers with severe dysmenorrhea. Examination reveals small uterus—shallow vaginal fornices. Repeated examinations for female sex hormone by the Frank method, taken at weekly intervals, showed negative results. At one time only was there a slight positive reaction. Tubes were found to be patent, and repeated Huhner and Condom tests were satisfactory. Diagnosis of hypoplasia was made. Patient received several diathermy treatments and came to the clinic off and on irregularly over a period of 2 years. In April 1931 she was referred to Dr. Milton Freedman in our Radiologic Department for deep x-ray therapy to the region of the pituitary and ovaries. Two weeks after x-ray treatment, blood examination was positive for the F. S. H. We did not see patient for about a year. She conceived in February 1932. Diagnosis was confirmed by the Aschheim-Zondek test. The first 3 months, the patient had intermittent attacks of bleeding and pelvic pain. She was kept in bed, given calcium lactate by mouth, and frequent injections of antuitrin "S", and Lipo-Lutein. Patient remained pregnant and was delivered at full term of a female child. Labor was protracted, difficult, and instrumental. At present, mother and baby are doing well.

This case illustrates hypoplasia (genital), possible adrenal disturbance (hypertricosis, funnel pelvis and male type), and faulty luteinization.

Case 4. O. E., aged 28, came to Gynecologic Clinic on Apr. 24, 1931. Complained of sterility. Married 8 years; never conceived. Hypertricosis on thigh and buttocks. Vagina constricted. Fornices shallow. Uterus, anterior small. Periods irregular—once in 2, 3, or 6 months. Weight 151 lb. Huhner test, fairly normal. Condom test, number of sperms diminished; few abnormal forms seen. Blood hormone taken 3 times, 1 week apart, negative. Hormone test taken from a 24-hour specimen of urine June 4, 1932, showed ovarian hormone, 4½ units; prolan, slightly positive (borderline relationship). Progynon was given by hypo twice a week, short period only. Patient could not afford to pay for medicine. Thyroid gr. ¼, 3 times a day. Treatment continued until July 12; weight 135½ lb.; thyroid discontinued because pulse became 100

Aug. 30, weight 133 lb. Periods appeared in June and August. Sept. 3, injections of filtered pregnancy urine were started—5 c.c. 3 times a week. Period Oct. 3, lasted 4 days, longer than usual. Treatment continued; last period Nov. 3.

This case illustrates diminished thyroid activity, moderate degree of hypoplasia, borderline balance between anterior pituitary and ovarian secretions.

Case 5. Mrs. M. B., aged 26. Feb. 25, 1930, applied to the Clinic. Sterility, 6 years. Periods always irregular, especially for last 4 years. Always delayed from 10 days to 2 weeks. Weight 156 lb. Cervix elongated; uterus small. Huhner test, unsatisfactory. Condom specimen, numerous live spermatozoa. Test for tubal patency, performed 3 times by Dr. Brams, showed normal patency. Pulse occasionally up to 100. Patient flushed, indicating vasomotor disturbances. Frank test on blood showed a sub-threshold estrin content. Placed on ovarian hormone therapy and bromides. Conceived twice; aborted each time at 7-8 weeks gestation. When periods were missed once more and patient began to stain, an Aschheim-Zondek test was performed and showed pregnancy. Patient was placed immediately on daily doses of Antuitrin "S", combined with 1 c.c. of Lipo-Lutein, and was confined to bed. Staining stopped after 1 week of daily injections. Injections of Antuitrin "S" alone were continued every other day for several weeks following. Later, patient received injections twice a week until 5 months pregnant. After that, injections were given once a week. They have been discontinued at present, the patient is about 6½ months pregnant—is in good general condition. (Antuitrin "S" is obtained from pregnancy urine and activates the anterior pituitary gland, which in turn stimulates the ovary; large doses cause luteinization.)

This case illustrates adrenal hyperactivity (vasomotor instability), hypofunction of the thyroid, faulty luteinization.

Needless to say, there are other cases under treatment which do not respond to the therapy described above. Failures are especially noted in profound genital hypoplasia, primary amenorrhea and congenital disturbances of the pituitary and adrenal glands. It is most important to recognize these disturbances early—in preadolescent and adolescent stages of development; only at those periods can we hope to make adjustments in difficult cases.

When the growth hormone becomes available commercially, we will make bigger strides in hormone therapy. The growth hormone is very perishable, and its extraction is at present difficult; whole pregnancy urine, used by us according to Dr. Mazer's technic, contains growth hormone, as mentioned above.

These cases demonstrate the necessity for careful and conscientious study; commercial hormones administered indiscriminately may cause harm. Flooding a patient with large doses of ovarian hormones may initiate a severe and prolonged bleeding, which may be difficult to control. It would be due to a persistent hypertrophy of the endometrium; in other cases it may further inhibit the pituitary gland and aggravate an already existing amenorrhea and oligomenorrhea. Excessive doses of anterior pituitary hormone may overstimulate the adrenals and cause vasomotor disturbances, or further aggravate symptoms due to a hyperacting pituitary gland. Thyroid medication, administered without basal metabolic rate estimates, may start a chain of symptoms of thyrotoxicosis.

MEDICAL ECONOMICS*

Francis A. Faught, M.D.,
Philadelphia, Pa.

The "Final Report of the Committee on the Costs of Medical Care" appearing with very little warning except to the initiated, took the medical profession somewhat by surprise, which, being news, was grasped with avidity by the press, which in turn, resulted in much unnecessary and considerable undesirable publicity. The fact that the Majority Report was accompanied by a Minority Report and a second Minor-Minority Report together with 2 or 3 Personal Statements in which were set

*(Read at the Annual Meeting of the Fifth Councilor District, at Salem, May 16, 1933.)

forth specific objections of certain members of the Committee to the *Report*, threw a controversial factor into the discussion.

There is no question that this *Report,* recommending as it does the socializing of medicine, by group practice, compulsory insurance, with eventual Government control, which this latter factor assures, threw consternation into the rank and file of the profession, whose general lack of information regarding medical economics was appalling, and who, fearing that which they did not know, expected that the complete socialization of medicine would promptly follow the recommendations of the Committee. Of course, nothing of this kind has occurred, and now 6 months after publication of Vol. 28 of the Committee's Report which summarized the investigations and set forth certain conclusions, which the minority group felt were not justified in the premises, we find that the course of medical practice has not yet changed in any important detail; that the socialization of medicine has been gradually progressing, for a number of years, and definite evidences of it were present long before the present depression struck us. The probabilities are that a gradual process of further socialization of medical practice will occur, unless organized effort is made by those most interested in maintaining their individualism and right to independent private practice, which shall also be supported by those in high places in the realm of medicine; and this will eventually engulf us as a profession, and we shall ultimately become the servants of the State, and the puppets of politicians.

Therefore, it may be said in the final analysis, that this *Report,* which many consider to be a pernicious species of propaganda, conceived by big business, and bred of a socially minded group of committee-men, the majority of whom receive their bread and butter from organized big business, is not the unmixed evil which many would have us believe. Students of medical economics throughout the country are beginning to believe that the result of this report will be a reaction which will defeat the purpose for which it was apparently devised. Already, medicine is being organized along intelligent, conservative, and far-seeing lines, which I have no doubt will perpetuate at least in our time, the type of medical practice that we have inherited from our forefathers in medicine, so that few of us will live to see the legitimate profits of ethical medical practice divided with a middle man, but we should not present a smug indifference to this and all other activities of a similar character because, like the original prohibition amendment, we might have something put over on us during our lethargy which, when we finally awaken, would reveal us hopelessly bound by legislation to support socialized medicine with all its inherent evils.

There are many who believe that some method must be devised to provide reasonably competent medical care to all persons irrespective of their economic status, because it seems evident that the burden of sudden prostrating illness, or a serious operation is more than those in the lowest incomes brackets can afford. What form this will take we can only conjecture, but judging from the experiences of the voluntary insurance schemes which have inevitably been forced into the compulsory insurance class, it is to be hoped that much careful thought will be given to voluntary health insurance in the United States before aiding it to become generally operative.

As we see it in Philadelphia, the sudden projection of the *Report* into the laps of the physicians has had a salutory effect, and we feel inclined to thank the Committee for having forced upon us what may be called *medical economic-mindedness.* The result of this quickening of our sense of our vanishing incomes has been to force us to take stock of the causes which have been operating to reduce it. The first effect of a realization of our rapidly diminishing income, was to organize a Committee on Medical Economics nearly a year ago, which has, with the assistance of a dozen sub-committees, acquired an immense amount of valuable information from which have already been formulated and adopted by the Philadelphia County Medical Society a number of basic principles relating to such matters as contract practice, dispensary abuse, mis-application of social service and encroachment of lay workers upon the medical pro-

fession. Now it may interest you to hear just what we have accomplished.

On May 11, 1932, following the request of Dr. William H. Mayer, then President of the Medical Society of the State of Pennsylvania, our County Society's Board of Directors prepared a series of resolutions bearing upon the proper method of caring for the indigent sick, particularly those who had been reduced to indigency by the "depression"; and, from the record, I quote the following selections:

(2) Any coöperation between the State and the medical profession must leave licensed practitioners to combat any effect, or any effort, on the part of the State or of industry to control the activities of the medical profession.

(3) Medical organizations must assume the leadership in all legislation pertaining to temporary emergency measures for relief of the indigent sick.

(6) Every physician who volunteers, or who is asked to serve, in this emergency work shall be remunerated in some manner similar to the remuneration for food, heat, clothing and shelter. A portion of the emergency appropriations should be ear-marked for the medical profession.

Other items called attention to the fact that the voluntary service of any physician should not be subject to legislation, and that physicians used in emergency work should be paid by the State or from local welfare organizations.

In August an informal meeting of several members of the Board of Directors decided to send a questionnaire to our members for the purpose of determining just how hard hit they were, and to learn, if possible, the causes of the reduction in income. A little more than 1/3 of the total membership answered the questionnaire; and some of the information obtained has been invaluable to us.

In January of this year were formulated what might be called fundamental principles of medical practice, particularly as it applied to our relations with the hospital and outpatient departments, the department of health, the lay boards of hospitals, contract practice, compensation practice, corporation contract practice, the widespread abuse of privileged communications, as indicated by the free reporting to insurance companies, facts relating to private patients, also the encroachment of lay workers upon the professional field, and finally the need for further post-graduate instruction of the physician. These recommendations were unanimously passed by the Board of Directors of the Philadelphia County Medical Society on Wednesday, January 11, and were presented at the general meeting held the same evening.

The purpose of this report, and its adoption by the Society, was first to provide a working platform upon which further activities directed toward improving the economic status of the physician, might be built. Secondly, to immediately furnish the rank and file of the profession with definite and tangible moral support; and thirdly this outline resulted in the appointment of 12 sub-committees.

In our outline of fundamental ethical and economic principles, we took the following definite positions: That free ward and dispensary service in hospitals should be restricted to the care of the indigent; that social service departments should cease to function as a money-getting branch of the hospital administrative department; that physicians giving free service in free clinics and wards maintained by approved hospitals or other charitable institutions or agencies, should provide, in their budgets, funds to be used as remuneration of physicians so serving, on the basis of service rendered for each individual patient. In regard to contract practice, we accepted the definition of the Judicial Council of the American Medical Association, and applied that as the yard-stick for determining the dividing line between legitimate and harmful forms of contract practice.

Admitting that contract practice, under certain conditions and in certain environments, need not be unethical or pernicious, we hold that contract practice is evil when it threatens the harmony and dignity of our profession through ruinous competition, inadequate medical service, controlled by laymen, the introduction of commercial methods, the direct or indirect solicitation of patients, or restriction of free choice of physician.

The problems of contract practice differ in each State. In Pennsylvania we have some extremely unjust and unfair workmen's compensation laws; in consequence of which we find indirect solicitation of patients, under-

bidding to secure contracts, ruinously low charges permitted, interference with free choice of physician, prohibition of suits against common carriers for nonpayment of bills, and limitation of maximum liability for medical service as to both the amount payable and the time during which compensation carriers are liable.

Concerning encroachment of the Department of Health upon private practice, cognizance was taken of the department's gradual usurpation of many duties which belong to the family physician. Since Dr. J. Norman Henry became head of the City Health Department we see evidence of better things to come. A careful study of the "Detroit plan" under Dr. Henry S. Vaughn, caused us to recommend its adoption for trial in Philadelphia.

The high-handed and often unethical practices of lay boards of hospitals, particularly as to removal and replacement of staff members, without consultation with the Staff, caused us to recommend that some plan be devised whereby the Major Staff should be represented at all meetings of the Trustees.

In Philadelphia there has been marked encroachment on private practice by large corporations and large industrial groups, a type of contract practice capable of perversion. Admit that in some instances, such as the examination of candidates for employment, or emergency work incident to plant hazards, it is praiseworthy; nevertheless, we found so many cases in which the function was carried over into the home, in the treatment of medical diseases, the immunization of employees against colds and other infections, that the Committee withheld its sanction from all such practices until opportunity may enable us to investigate the legality of corporations entering into the practice of medicine. The persistent efforts of many Insurance Companies, particularly those insuring against accident and sudden illness, to secure information without the payment of a fee, brought to light another source of loss of income, and since the supplying of such information requires expert interpretation by the physician who collected it, and then his preparation of a formal report, before it could be of any use to the Company, and since this requires time and effort, as well as technical knowledge, it was deemed desirable that an effort should be made to establish a reasonable fee for such service.

The encroachment of lay workers on the professional field is well known; but the extent of it is hardly realized. There is no question now that much of the work of partially trained professionals, such as nurses (trained, practical, visiting, school and industrial), is actually the practice of medicine and, therefore, legally beyond their proper sphere. An outstanding type is that of the "nurse anesthetist", who has in our State and in many others, almost completely occupied a field that legitimately belongs to the medical practitioner trained in anesthesia.

Here it was recommended that a thorough investigation be immediately instituted, and the State Board of Medical Licensure be requested to assist in determining whether such custom is in violation of the Medical Practice Act.

In the interest of public health, it was recommended that the Philadelphia County Medical Society coöperate in developing its already popular system of Post-Graduate instruction, in order to keep the rank and file of the profession informed as to scientific progress, and that eventually we might be able to secure cooperation of the medical colleges in providing more practical and less theoretic medical instruction.

Immediately following the meeting at which these basic resolutions were adopted the Committee organized an educational campaign for the purpose of acquainting members of the Society with the present trend of medical economics, and for the purpose, particularly, of soliciting their individual support. This was accomplished by means of a Speakers' Bureau, and arrangements with 40 medical societies, which meet monthly in Philadelphia, to place upon their programs one of our speakers.

You will be wanting now to hear something about our results. Even so soon, a few months only since the Society took up these matters, we can report satisfactory progress. In the matter of hospitals engaging in contract practice, we caused several to turn "about face",

and prevented others from starting with plans already under consideration.

The Sub-Committee on Contract Practice has already entered into an agreement with the Insurance Carriers to the end that there shall be immediately formed a Joint Committee of Physicians and Carriers to act as an Arbitration Board for the settlement of disputed bills, and both parties to this agreement must abide by the decisions of the Board. The Carriers have also agreed to use a minimum fee bill which shall serve as a basis for uniform charges in practically every ordinary accident, injury or condition that may demand compensation.

Finally, in the matter of contract practice, the County Society has authorized the formation of a *Court* whose duty it shall be to investigate all forms of contract now existing between its members and any other organization or agency, and to warn any member whose practice is found unethical or contrary to the best interests of the patient or physician. Its duty shall be, also, to investigate new contracts anticipated and, if they be found unethical, to require their correction prior to their adoption. This Court is also provided with penalties to be inflicted; (1) upon those now working under an unapproved contract, who will not agree to discontinue them upon their existing expiration date, and (2) upon all those who shall from the present date enter into any unfair or unethical form of contract.

I have presented this rather disconnected talk relating the activities of the Philadelphia County Medical Society in the field of medical economics, not with any thought that any other county or city possesses exactly the same problems, but because I feel that the harmful agencies and activities which we have discovered and are endeavoring to correct, have their counterpart in many other places, and feel that due publicity should be given to these activities so that any part or parts of our plan may be adopted by other Societies, to the end that the medical profession, throughout the Union, may present a solid, logical, reasonable and fair front to the public. By education and precept we may succeed in correcting many erroneous ideas now existing in the public mind regarding the business side of the practice of medicine, that during the evolution of certain adjustments that are bound to come, and which are a part of the present economic unrest, we shall have a sympathetic public, made sympathetic to our ideals by having been taught that the conscientious and ethical physician is primarily interested in the health of the community, and is willing to sacrifice much in any effort to improve it. Our opportunity to secure this public support rests largely upon our approach in matters of publicity and education. To this end, every effort should be made: to keep constantly before our patients the basic principle that organized medicine, as it has done in the past, is doing now, and will in the future endeavor to provide adequate medical service to all; that this can best be accomplished by maintaining the highly desirable and confidential relationship of individual patient with his private physician; that this relationship is very likely to be disrupted if business interests and politics be permitted to exact a middle-man's fee from medical service; that despite specious arguments, contract practice and compulsory health insurance, as at present outlined, are inimical to the best interests of the individual patient and contrary to public welfare; that in order to preserve the family physician, and through him to provide for every individual competent medical service, it is essential that the physicians of this country be guaranteed an economic competency, in order that their professional activities may not be hindered or restricted by unnecessary worry regarding finances—and the future.

RELATION OF THE OUT-PATIENT DEPARTMENT TO MEDICAL ECONOMICS*

L. Waller Deichler, M.D.,
Philadelphia, Pa.

There are 2 factors involved in the problem of relation of the Out-Patient Department to medical economics: (1) that dispensaries have always been abused, and (2) that the doctor himself is chiefly responsible for this abuse.

*(Address delivered at the Fifth Councilor District Meeting, at Salem, May 16, 1933.)

When Philadelphia was founded, the care of the poor and sick was readily solved. With its growth, however, the proposition grew; and to meet changing conditions, the "Bettering House" was established. Here a room was set aside for the care of indigent medical and surgical patients, and the first hospital was created. A new problem then developed. There were a number of persons who needed medical aid, but who were ambulatory and did not need full hospitalization. In consequence, about 1786, the first Dispensary was inaugurated.

"Every created good, when perverted or misapplied, becomes an evil." About 6 months after inception of this dispensary, a paper on dispensary abuse appeared; and this condition has continued ever since. Unfortunately, it has grown steadily worse, and today assumes a prominent place in our scheme of medical economics. Opinions on the extent of dispensary abuse, however, present vast variations. One extreme believes that not more than 2 or 3 out of every 100 patients are undeserving of admission. The other states that practically every patient can pay something. Analysis of a questionnaire sent to many Philadelphia physicians reveals dispensary abuse as responsible in internal medicine to the extent of 40% of patients treated; in part-time specialties, 30%; and full-time specialties, 26%; with an average for all classes of 32%. It is an established fact that fully 76% of the patients presenting themselves for free treatment, in the Out-Patient Departments of our hospitals and other free health agencies, are able to pay. Their attendance is due in part to the depression but mainly to the indifference and almost complete lack of supervision which prevails.

Hospitals were started by physicians, but before long they grew too large for them to handle unless they gave full-time service. Laymen were brought in, forming a Board of Trustees, but the medical men having representation and forming a part of its personnel. The hospital continued to expand; more and more elaborate buildings and equipment were provided; and it became too large for the Board to handle. A Social Service Department was then established, to coöperate with the physicians and among its varied duties was careful investigation of the financial status of applicants for admission, making sure that only the indigent were given medical and surgical treatment, and, either free or at a nominal cost, the necessary medicines. The doctor, who has always been considered a poor business man, has gradually been displaced on most of the Boards, and the Social Service Department, now, does not function as it should. The only patients investigated by it are those who pay nothing. It encourages the able-to-pay patients without investigation. No attempt is made to separate the indigent from the affluent. This Department welcomes, without question, every patient who applies to the Out-Patient Department for medical or surgical attention; collects a fee of from $.50 to $2 for registration; permits the patient to continue attendance; and, through a follow-up system, makes him feel that it is mandatory for him to return to the clinic rather than to his private physician.

Part of this failure is due to the innate selfishness of men, and part to the acute effort for survival. The first of these is represented by the hospital Superintendent. If the hospital cares for 15,000 patients a year, the Superintendent assumes a place of importance among his less successful colleagues, who can boast of but 5000 patients a year. Then, too, he can demand a better salary. This is retroactive in every institution seeking financial aid from the State. His Board of Trustees can appeal for a larger appropriation, upon the basis of the work done; therefore, increasing pressure is brought to bear upon the Superintendent by his Board, and passed on, through him, to the Social Service Department to "admit as many patients as you can". The greater the number of patients, the happier the Superintendent, the more secure the jobs of the Social Service Workers, and of course, the less the income of the private physician. In most hospitals the Social Service Department has taken all control from the out-patient staff, and deliberately decides who shall and who shall not be treated. Two months ago, in one of our hospital dispensaries, a patient came for a tonsillectomy. The father has been employed throughout the entire depression period, with but a 10% and a 5% cut in wages. The attending physician remonstrated with the head

of the Social Service Department and was informed that he must accept any patient sent by the Department, and if he did not like the way the Department handled patients, he could discontinue his service as a dispensary physician. Surely in such instances the hospital physician does not receive as much consideration as that given the help in the hospital. In another of our hospitals, the arbitrary rate of $50 a week income determines whether a patient is or is not a suitable case for dispensary care. If he earns less than that sum, he is indigent. Another Superintendent has made a statement to the press that his hospital cannot afford to give free treatment to any one who is employed, and intimates that glasses will only be given to those who can afford to pay what the hospital cares to charge for them. No hospital has any right to give treatment to any one who is employed; the employed belong in the doctor's office.

Philadelphia is over-hospitalized. All are more or less supported by groups of individuals, welfare organizations, churches, etc. All are over-equipped, over-manned, and contain about 40% empty beds and too many non-supporting accommodations. This reflects great mismanagement, for which the pay-patient must and does pay. Almost all our hospitals are bankrupt, and some will be forced soon to close. Today, the difficult problem is to keep going, because of the yearly deficit. This deficit, without a report showing a great number of patients under observation and a large amount of work performed, would cause unpleasant action from the Board, which is often under the domination of lay trustees, who in turn are influenced by a host of secular and other lay organizations. Lay Boards are determined that hospitals shall be maintained. They do not find mismanagement the cause of their trouble, but blame the competition of the great bulk of individual practitioners. This competition must be effaced and the strongest weapon in their hands is active, deliberate solicitation of patients at any price.

But then it is discovered that there are not enough patients to go around. The hospitals continue to lose money. How natural a step, then, is the establishment of many iniquitous practices to augment the income of the hospital. Drug Departments were started to protect the poor from the corner pharmacist, and prescriptions were furnished at cost. Now, the prescription is furnished at retail price, and most, if not all, hospitals show a substantial profit at the end of the year in this Department. In consequence, the old-time pharmacy has become a combination department store and lunch counter. In the Eye Dispensary, patients were refracted for nothing, but no longer does the patient have his choice of one of several opticians to make his glasses. The prescription is sent to one definite optician, as a recompense for gifts in the form of donations or equipment to the hospital. But why divide the profit? Always altruistic in protecting the poor, several of our hospitals have now established their own Optical Departments, and discontinued referring their optical prescriptions to retail opticians. They have virtually entered the retail optical business, in direct competition with the legitimate tax-paying opticians, by having their optical prescriptions filled by a wholesaler, at wholesale prices, the finished product being dispensed by the hospital at prices equaling, or closely approximating, the charge made by the retail optician. In some hospitals, under this plan, the profit is still split between the optician furnishing the glasses and the maintenance of the Optical Department, but in one of our Eye Hospitals, in 1931, approximately 12,000 patients were admitted: 11,000 of these were given glasses at a gross cost of $77,000 (averaging $7 per person), and at a net profit of $32,179. Charity has become a racket.

During the War, when many of our colleagues were in the service, the wonderful "Philadelphia Idea" was born. Brilliant in its conception, evil quickly appeared. Many patients who should have gone to a fellow-practitioner left in charge of the practice of the man "over there", reported to the Out-Patient Department of our hospitals, and instead of being sent back to the doctor, were gladly received at "so much a treatment", which moneys went to the hospital. The attending physician received nothing for his service, and the family of the absent physician was robbed of a much-needed income.

With this experience before them, it was

but a natural step to enter into an agreement with the industrial plants in the neighborhood, whereby victims of compensatory accidents that were not too severe were admitted as a special class to the dispensary, at $.50 and $1 a treatment. These patients were, and still are, given a card of different color from that of the regular patient, and the nurse in charge of the clinic is instructed to call the physician's attention to the patient as soon as he appears. Then, irrespective of how many are ahead of this favored person, or how long a time these people have waited, the medical attendant drops everything and gives the "special" whatever attention he needs, so he can return to work with as little loss of time as possible. A careful record of these patients is made by the Social Service Department, and when the patient is discharged, a bill is forwarded for the amount due. The doctor, however, is not paid.

Compensation insurance companies were not slow to see the possibilities of such a racket, with augmented earnings to themselves. In consequence, in practically all of the hospitals in Philadelphia, compensatory patients are referred to dispensaries, in some cases favorites of the Company, and a nominal charge collected by the hospital for caring for such persons. Inadequate though the State Workmen's Act may be in its provision for the medical care of the injured employee, it takes him out of the category of the indigent but the doctor has been denied his just remuneration. Should the one injured need hospitalization, he is sent to the hospital and placed in the ward. Fees are collected by the hospital, operative fees included, but the staff receives nothing.

The Welfare Committees and Workers, the Social Service Nurse, the Health Center Nurse, and to a lesser degree the School Nurse, have gradually lost their idealistic positions. Today, without proper investigation, many patients who could afford to pay something for their medical service are referred, with notes, to dispensaries, or at times, groups of 8 to 15 children are corralled together and herded into the clinic. Much of this is the result of indifference on the part of this group, but selfish ambition may play a part. Men and women occupying these positions, almost always remunerative in character, so cherish their affiliations that they are loath to support any movement that might endanger their connections. Hence they are guilty of aiding and abetting this pernicious habit, by encouraging the attendance of patients without an attempt to separate the needy from the able-to-pay, and through their follow-up service which makes the patients feel it is compulsory to return to the clinic.

The abuse of the accident ward in every hospital exerts its malignant influence. This is especially true at night, when many who are not emergency or accident patients present themselves for treatment. None are turned away and frequently no charge is made. To these must be added the large number of patients who apply for first aid. A majority of these make but one visit to the clinic, and can well afford to pay, but are not called upon to do so. If follow-up treatment is necessary, almost invariably they are told by the intern or nurse on duty to report to the proper dispensary for subsequent treatment. Those in more serious condition are admitted at once to the ward.

Concerning the doctor himself, much might be said. He is responsible for hospital abuse in perhaps 50% of the cases. For example, the family doctor has a patient in need of special study—laboratory, gastro-enterologic, or x-ray, perhaps—or a patient is in need of the services of one of our colleagues limited to one specialty. Often because the attending physician feels that he is making a wonderful impression on the patient, he refers him, with a note, to the hospital clinic, telling him that Dr. So-and-So will take care of him, and it will not cost him anything. Some of these men have been found collecting fees from these patients after admission to the hospital. They call on the patient and charge for the visit. Sometimes the physician is not guilty of this "grand-stand play" but, because he is familiar with the financial status of the patient, is honestly seeking to have the work done at as little cost as possible. He feels that the specialist will charge more than the patient can afford. This is not true, but because of either of these influences, the patient lands at the hospital and is promptly admitted and treated. Is it any

wonder, therefore, that the Out-Patient Clinic is over-crowded? The average clinic is undermanned, and the service rendered, therefore, can at its best be but routine and perfunctory; yet the doctor is satisfied to continue under these conditions.

What can be done to correct these influences, which have robbed us of our income? The great concern for the indigent sick is likely to have its origin in insufficient information. The doctor began his care of the poor from a humanitarian impulse—the urge to help. He has always taken care of them, and always will. In recent times, however, he has been unconsciously "breeding paupers by educating parasites". In its final analysis, the medical profession is not responsible for the indigent sick, but is merely responsible for giving the very best medical care. The indigent, well or sick, is a community liability. Every item, except the compensation of the doctor, is paid for either by the State, the municipality, or philanthropic agencies. Government care of the indigent should be extended, with the ultimate object of relieving the medical profession of this burden. Why should the medical profession be so discriminated against? If the physicians of Philadelphia insisted upon a fair compensation for all services rendered, the public would be better served and hospital deficits would be reduced. Just so long as dispensaries are under the control of indifferent clerks and social workers, who are subservient to a lay board of trustees, with dominating ideas as have been mentioned, just so long will the present evils exist. Therefore, I believe that the lay board and superintendent of every hospital, and every lay organization connected with it, should coördinate with the medical board, with a better understanding of the problems of the staff and an intelligent coöperation with it. There should be a sensible investigation to determine whether patients can or cannot pay. The Social Service Department should function for the benefit of the physician as well as the hospital, and its control should be taken out of the hands of inefficient clerks and given to the hospital staff. No doctor should be forced to give free service to anyone not entitled to it. There should be a greater appreciation of his inalienable right to decide whom he shall treat gratuitously. The conscientious doctor serving on the staff or dispensary of any hospital should therefore investigate the efficiency of the Social Service Department, seek to correct any inefficiency, and refuse to treat any able-to-pay patient, even though he has been passed by that department as indigent. No hospital should be permitted to conduct unfair competition with the private physician. Why not have patients pay to the hospital the same fee as would be charged by the family doctor? If this was done, the patient would soon leave the hospital and consult the doctor in his office. The dispensary doctor should be paid an equitable amount. Instead, some of our hospitals charge $20 for any surgical operation and pay the doctor $2 an hour, for 2 hours a day. The fact that the dispensary doctor should be paid, however, does not in any way lessen the responsibility for careful investigation of the patient as a legitimate case. Hospitals conducting retail Optical Departments are doing that which the ethics of our profession condemn; namely, participating in the profit that may accrue from the filling of prescriptions. They have become a source of danger to the public welfare, in encouraging exploitation of the public for pecuniary gain, to the direct loss of income both to the doctor and the legitimate optician. This should be discontinued. The staff of any hospital conducting its business in such an unethical manner is just as guilty and unethical as the hospital itself, so long as it condones such conduct.

The Out-Patient Department should refuse to receive compensation patients, and the abuse of accident wards should be stopped. First-aid may be rendered and the patient then referred to the family doctor or one competent to care for him. If conditions will not permit sending the patient from the hospital, he should be referred to the semi-private ward or a private room, and the staff physician, responsible for such a patient, notified.

The intern staff should be supervised and instructed. Perhaps this can best be effected by reorganizing the medical course in our Universities to meet present changing conditions.

It should, at least, include in its curriculum a comprehensive course on medical economics.

The family doctor should be discouraged in referring patients to the hospitals. I believe, if no patient was admitted to the Out-Patient Department except with a letter from the family doctor, practically all dispensary abuse would cease. If the patient is ambulatory and is sent for diagnostic survey, the report of the findings should be sent only to the doctor referring him to the clinic. Stop the iniquitous practice that if too poor to pay for his services, the patient becomes the property of the hospital, and is notified to return to the hospital for free treatment, and warned not to return to the family doctor.

The public must have its individual doctor. Every doctor has always been willing to call at the patient's home, or to treat him in his office, no matter what his financial status may be. If poor, his medical attention is given gratuitously. If he is in the middle working-class, he pays what he can, regardless of the amount of the bill. Every specialist is willing to accept the fee the physician referring the patient arranges for the patient to pay, if the physician is fair and equitable in his relations to both patient and consultant. Dr. Anders said about 2 weeks ago that 100 specialists met recently in London and agreed to accept smaller maximum charges for consultation services, and suggested that it might be well for the specialists in Philadelphia to follow their example. No such agreement is necessary—the Philadelphia specialist, with but few exceptions, has always been willing to charge what the patient can afford to pay. If we may accept the answers to the questionnaire: In general practice 90% of the patients do not object to the charges made; and in specialist groups, 79% do not object.

In closing, may I quote Dr. Donaldson, who says, "The medical profession offers its history of altruism and capacity to serve, as justification for its claim to control its own affairs." We see this effort for control upon every hand, but to be effective, there must be organization. Organize, gentlemen, and the problem is solved.

THE DEPRESSION

Everybody bears a tale of woe,
And most of all they want to know
What is causing this confusion.
Are they nursing a delusion
That the world has wrenched a cog,
And they feel jolting and ajog,
That keeps them rolling like a log
'Till their minds are mixed with fog?
Things they know are all disjointed,
Yet not one the plan has pointed
How things direly disconnected
Instantly can be corrected.
They are looking quite dejected;
What thing else can be expected?
Some have joined in dissipation
That has almost wrecked the nation:
Buying phony lands and bubbles
That were naught but air and stubbles;
Buying long and selling short,
Gambling all and called it sport;
Building castles high in air
With no base their weight to bear;
Making millions on the ticker,
Selling stocks without a dicker;
Bulls and bears, their hides exchanging,
Through the stock exchange e'er ranging.
Luring lambs in to their slaughter,
Fleecing, bleeding with a hauteur
That befits the jungle habit
Not unlike the wolf and rabbit.
The Depression has its merit,
If folks only grin and bear it.
Takes them back to days of yore,
When they skins and homespun wore.
When the sky was roof and cover,
Round the wood-fire each would hover.
Food was found in stream and forest,
Hunger haunted, want was sorest.
Times were those that tried the soul,
Yet they urged men to gain the goal
Of achievement, art and learning,
Kept the torch of Freedom burning.

—Elton S. Corson, M.D., Bridgeton

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive it regularly will confer a favor by notifying the Chairman of the Publication Committee.

NOTE.—The transaction of business will be expedited, and prompt attention secured if:

All papers, news items, reports for publication and any matters of medical or scientific interest, are sent direct to The Editor, DR. HENRY O. REIK, Vermont Apartments, Atlantic City, N. J.

All communications relating to reprints, subscriptions, extra copies of the JOURNAL, books for review, advertisements, or any matter pertaining to the business management of the JOURNAL are sent to THE CHAIRMAN OF THE PUBLICATION COMMITTEE (address above), Newark, N. J.

A STUDY COURSE IN MEDICAL ECONOMICS

A chance remark, made recently by a member of the State Society, revealed that he and many of his colleagues had come to look upon the Journal as offering what the Editor had hoped it would prove to be—a study course in medical economics—through the papers and discussions of this subject published therein. Thinking over that interpretation, it occurred to us that it might be helpful to other members of the Society to review this course in that light.

Our method of dealing with the "Final Report of the Committee on the Costs of Medical Care" was devised, you may recall, mainly for the purpose of assisting the members of this State Medical Society to acquire accurate knowledge of the fundamental facts out of which the *"Report"* grew, and from which they might select such bits of information as might seem essential to their construction or development of personal conclusions. Our comprehensive abstract of the *"Report"*, while intended primarily to "make a long story short" for our readers, was constructed also with a view to emphasizing its educational value. Spurred on by the popular response to that effort, we followed up with additional material of informative character in the April Journal; this consisting largely of reports concerning the handling of the same problem in other States and by our own Component County Societies.

Meanwhile, our Tri-State Conference was among the first (if not indeed the *very* first—with the exception of the discussion at the New York Academy of Medicine when the *Report* was made public) of all medical organizations in the United States to take up the Wilbur Committee Report for serious consideration; its scheduled meeting of December 11, less than 2 weeks after the *"Report"* was publicly launched, presenting a program devoted entirely to that subject, and published in the Journal. Since that time, innumerable National, State and County Medical Societies have discussed the subject, and from various points of view. Not within our recollection has any other topic received such thorough or such widespread consideration.

In New Jersey the ground has been fairly well covered by our organization. Most of the County Societies discussed the question at one or more local meetings; in some instances, informally among themselves; in others, by general discussion after presentation in a more formal manner by a Guest Speaker selected,

in most instances, from among those who had served on the National Committee. In some Counties special Committees were appointed to study the *"Report"*, and from a few of those we received and published the results of their studies.

In addition, the subject was dealt with at the Annual Conference of County Society Secretaries and Reporters, and at the Councilor District Meetings, and reports of some of those discussions were published in the Journal.

Finally, our State Society's Welfare Committee authorized, and its Chairman, Dr. Schlichter, appointed, a special Sub-Committee to study the *"Report"*, with a view to advising the State Society at its Annual Meeting what, if anything, should be done in the matter. At the Annual Meeting, the Welfare Committee submitted 2 reports prepared by its Sub-Committee, and, later, the entire subject was re-viewed and re-stated by invited Guest and Member Speakers at an "Open Meeting" during the Convention, when the "high water" mark of this course was reached.

The Journal, besides its January and April issues, and publication of the various other discussions and actions cited above, continued to devote as much space as could be afforded to the offering of other material which the Editor deemed worthy of inclusion in this educational program.

The symposium of 4 interesting talks presented on that occasion by Drs. Ross, Hartwell, Morrison and Sherman, is offered for your further "education" in this issue of the Journal. The Chairman of the Committee, the late Dr. W. Blair Stewart, did us the honor of asking our assistance in the selection and procurement of speakers for that session. Dr. Stewart wished Dr. Morrison, as an Officer of the Society, the Secretary (using the word "secretary" as connoting the mouthpiece of, or speaker for, an organization), to summarize the existing situation regarding the Wilbur Report, and he requested us to complete the Program. It was not an easy task, but, as we look back upon the results, we feel rather pleased with what was achieved.

For one thing, we had as an opening feature a clear-cut picture of the problem confronting the profession, and that is a factor essential to a proper commencement of our study, and a contribution for which we cannot sufficiently thank Dr. Ross.

The other 3 papers presented equally interesting and varied points of view. It is curious how differently people see these things. The National Committee presented not only a Majority and a Minority Report, but several subsidiary minority and individual reports. Likewise, our small Welfare Sub-Committee, consisting of only 5 members, all drawn from a small area within this State, handed in Majority and Minority reports. It would seem as if *agreement* regarding this matter, even as to the character of the problem itself, let alone the question of action thereon, is practically impossible when 2 or more take it under consideration.

We hope you will read, very carefully and thoughtfully, all 4 of the papers comprised in this symposium, although for the present we will make specific reference only to the first of the collection.

Dr. Ross is not at all pessimistic, and we like the way in which he posed the problem; saying, almost in his opening sentence:

"Medicine's problem is to correct defects in its services so that they will meet present-day needs, and to make necessary adjustments in relationships to bring this about. * * * The position of the profession in public opinion will depend upon what it does to meet new conditions and not on how much it objects to situations brought into the open by various studies and investigations. The profession of medicine has the matter in its own hands, since it is the only authoritative source of medical knowledge, and it will not allow the situation to go by default nor permit unsound programs to become established. I am sure, from personal observation, that the profession of medicine, as a whole, is emerging from its 'state of lethargy' and is moving toward consideration of the public aspects of medicine."

We shall hope to follow this still further next month.

Esthetics

TUNEFUL TRIO: HERRIOT, WOODIN, MUSSOLINI

From the Literary Digest of May 6, 1933, we have abstracted the following interesting story concerning 3 of the world's great men of this period.

The Dictator of Italy with his fiddle, the master of Uncle Sam's moneybags with his guitar, the financial envoy of France at the piano. There's a trio that would pack the Metropolitan Opera House. Theoretically, it is one of the concert possibilities of current musical statesmanship, or statesmanly musicianship. And that illustrious trio would swell to a still more illustrious quartet, if reënforced by a former Prime Minister of Poland—the immortal Paderewski, who is even now besought by his patriotic fellow countrymen to return to the helm of the storm-ridden Ship of State.

What of a concert program for these international harmony boys? Its scope should be world-wide, of course. Some composition of Paderewski's might be included as a compliment to the venerable Polish virtuoso.

And our own Will Woodin?

Well, no doubt the other musical statesmen of the band would be glad to join in rendering a melodious *opus* by the Secretary of the United States Treasury. Some of Mr. Woodin's more serious compositions have already reached the dignity of being interpreted by symphony orchestras, and that's a big "okay" for an amateur who started his composing on a guitar.

Attention has been drawn lately to an apparently close relationship between the ruling of nations and their treasuries, and the juggling of sharps and flats. In that connection, the example of Mr. Woodin is of the most timely interest to American readers. It is worth introducing with the stunning anecdote we shall now re-tell.

Listen! The bedside telephone rings. The sleeper stirs, but only to snuggle deeper into the pillow. Dawn has not yet paled the night. The city is wrapped in pre-milkman peace. "Ngrrrrrr", sings the telephone. And again, rhythmically, "Ngrrrrrr—ngrrrrr—ngrrrrr—" The sleeper moans, half opens one eye, flings out an arm and seizes the pertinacious instrument. "Hello! Who the—what the—" "Say, Charlie", comes a clear, lively voice over the wire, "this is Will Woodin. I want you to hear something that just came to me. Here it is—listen."

Out of the earpiece kerplunks a booming chord fit to arouse the 7 sleepers, for behind it is all the cavernous resonance of a big guitar. Then a couple more chords, and then a thunderous plunkety-plunking of strings in a jolly rhythm that weaves itself into a whimsical tune.

"Charlie" was Charles Miller, Mr. Woodin's music publisher and fellow conspirator. "Drowsily but dutifully he transcribed the air into notes, and, hanging up, rolled back to sleep," relates Jack Alexander in the St. Louis Post-Dispatch, and he adds: "In the Woodin penthouse the composer laid aside his guitar and was soon asleep." In that same New York penthouse, we learn elsewhere, Mr. Woodin has "a guitar in every room", and he has a habit of waking at 4.30 a. m. and proceeding to settle unsolved problems, financial and political as well as musical.

Few knew of his accomplishments in the musical world until the announcement of his appointment to President Roosevelt's Cabinet, remarks Charles W. Duke in the Philadelphia Public Ledger Magazine, adding:

Not even Tin Pan Alley, with its knowledge of who's who along the Great White Way, guessed that the man who wrote the music for "Dancing to Heaven With You" and "Spring Is in My Heart Again" was the same William H. Woodin who signed the fiscal reports of several of America's largest business corporations.

A lot of fun has been poked at the new "Woodin money" appointee for his supposed "hot-cha-cha" airs. But, as a matter of truth, and as pointed out by Dr. James Francis Cooke, the Philadelphia musical publisher, Woodin's musical attainments are not of the Tin Pan Alley variety.

Among his compositions are five symphonies, a children's book of songs, and various popular pieces far above the ragtime type. "Oriental Suite", one of his compositions, was recently performed by the Philharmonic Orchestra in Berlin. In February the Manhattan Symphony Orchestra, in New York, played a group of 4 musical compositions by Woodin: "Chinese Magic"; "The Unknown Soldier"; "Souvenir de Montmartre"; and "Tartar Dance".

Critics who had never heard of Woodin as a musical composer pronounced his work "as showing seriousness of purpose and a solid foundation of musicianship". This serious business of musical composition began only 3

years ago, and his first compositions were for the guitar.

Reversing Nero, "Il Duce" fiddles while Rome is being built up to a modern version of its ancient glory. Mr. Duke, who reviews the world-wide field of statesmanship in relation to music, tells us in his Public Ledger article: "A student of Aristotle, and of Plato, Mussolini declares he has learned from these ancient sages that the cult of music deepens the harmonies of the soul. At least 5 valuable violins are known to be among his sacred treasures. Friends say that when he has played for 10 minutes, he is so swayed by the soothing strains of the strings, that his face pales and his eyes close while he gives himself utterly to the mood of the moment."

And then Mr. Duke turns to a French statesman who is no stranger to Americans, telling us that: M. Herriot plays the piano, mostly by ear, and it is his favorite form of relaxation. He is a writer, too, and is now engaged in writing a life of Beethoven. As a compatriot facetiously remarked of him recently: "France is not a musical country and a French statesman with musical associations is a rare bird."

We are reminded that Mr. Woodin had, in a way, a musical fore-runner in Washington—that is, if we accept the unofficial view that he "succeeds to the portfolio of music vacated by the redoubtable 'Hell 'n' Maria' Charles G. Dawes, who, through 3 successive Republican Administrations, might have been dubbed Secretary of Music, had there been such an office in the Cabinet. * * * Before he was Director of the Budget, Vice-President, or Ambassador to Great Britain, this dynamic Chicago financier, with a penchant for underslung pipes and fortissimo expletives, had proved himself a musician of rank. Always a lover of music, a violinist, and a composer of pieces he played 'for himself only', he finally got one of his inspirations into print, in 1921.

It bore the simple label of 'Melody', but soon became a melody heard round the world. Fritz Kreisler put it in his recital programs. England, France, and Sweden joined America in rendition of the Dawes piece. President Masaryk, of Czecho-Slovakia, said it was the logical successor to Dvorak's 'Humoresque'."

Mr. Duke reminds us that Washington was painted playing the flute, that Jefferson played the fiddle, and Franklin invented an instrument of musical glasses on a revolving treadle.

Lighthouse Observations

LEGAL RESPONSIBILITY OF THE GYNECOLOGIST

(We are pleased to present this month some extremely interesting information offered by Dr. E. J. Ill in an address to the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, September 12, 1932.—Ed.)

It seems preposterous, almost, to present this subject to you. But we have never discussed it in all the 44 years of this Society's existence. The subject has affected many of us and 3000 cases have reached the upper Courts. The writer is thankful that he has been spared this ordeal, though he may hear of it tomorrow. For our mutual protection it would be wise to discuss it.

The writer learns from one of the large liability insurance companies that 17% of the physicians insured by them during the years 1929, 1930 and 1931, registered as gynecologists or obstetricians; and that loss incurred by all practitioners except these 2 groups is 57.2%, while the loss on gynecologists and obstetricians is 51.3%. In other words, we are singled out for special attention. This alone deserves our study, attention, and discussion as a matter of self-protection. If we receive special recognition by the laity, preparedness in the shape of high insurance protection is a duty.

It is apparent that as soon as our profession declares openly that we are able to do things particularly well, in other words profess special knowledge, so soon will we be called upon to be liable in a special degree. The gynecologist at present is the person in question. It is one of the objectionable features of specialism. We offer our services where special knowledge of diseases of the female pelvic organs is required. Of late we are demanding special recognition because some of us have become members of the American Board of Gynecologists. This special recognition carries added responsibility. The most important point here is that we shall not have the backing of the court that a general practitioner has when the court will instruct a jury by saying: "The defendant, the general practitioner, possesses such a degree of learning and skill as is ordinarily possessed by the physician and the surgeon in the locality where he practices." We, as gynecologists, must possess the very highest skill and learning, and apply that knowledge to our patients. Nothing could be fairer than this. Our opinion as to treatment and after-care need not, however, be standardized or measured by common practice, among practitioners in this line, and because we consider ourselves authorities in this work. Our own result and judgment must ever in Court be a criterion of our actions. In this our colleagues will stand by and protect us. We shall be told this when we are brought before the Court as defendants in a malpractice suit. An action for malpractice is an action in negligence. So simple a thing as to overlook a piece of gauze left in the vagina on the patient's discharge should be guarded against. Much more serious is the result of foreign material left in a wound.

It behooves us to guard against any chance of thus being treated. We may innocently make an error which gives cause for complaint. Fatigue and worry and technical obstacles may be at the base but that, in a Court, does not clean our skirts.

In a way we shall always be obliged to engage assistants, be they doctors or nurses, but we shall

always be liable for their actions both morally and in a legal way. Let us remember that the patient's rights are preëminent, and these rights we must and do respect. While we surgeons must ever protect one another against fake accusations, there must be a limit to such protection if we wish to retain the respect of the court as well as the laity. Let it once be known that we protect each other whether guilty or not, neither court nor jury will believe a word we say. If the accusation has any foundation for gross or criminal negligence, it will be well to withdraw our support and let the court decide. In withdrawing our support we, nevertheless, must be mindful that the whole and only truth shall be placed before the court and jury. Let us not forget that there is an immense amount of uncalled for gynecologic surgery and mutilation performed. Unless we curb our experimental surgery and base it on true pathology and on experimental surgery on the lower animals, there will soon be a demand for a why and a wherefore. Where we might fail, however, is that our action is not based on the true pathology as understood at this date. Belief and opinion have no place in the court today when they are contrary to present-day pathologic data and experience. Pathologic views that were considered right in the past and that have been abandoned are no excuse for our actions and would fail in a court of justice. It would be eminently unfair to our colleagues to ask them to protect us under these conditions. A report of the pathologist that normal organs have been removed is not to our credit and will be a factor in court. The pathologist often enough at this date finds fault with our work. But, on the other hand, he may be complaisant, and thus protect the operator. However, if sections or whole organs are demanded by the court, we shall surely be obliged to show, from our written records, that we had exhausted all of our means to a clear understanding of the case and that our opinion at the operating table was verified by the finding as we judge it to be, though at variance with the pathologist. We must be able to show that what we found at the time of the operation, when at variance with our diagnosis, could not have been diagnosed until such time. In particularly doubtful cases it would be wise to give the patient or her doctor a written record of our opinion. Of this we must keep a copy. If we find a pathologic condition unlooked for, we may safely perform such work as is indicated. The patient's suit for assault, of which we hear so much, would have no basis of fact. If we did not do so, she would have reason to complain, with a fair chance of recovery. The case of Benner vs. Parsonette has definitely settled this matter in the Supreme Court of New Jersey through its justices. Dr. Parsonette found matters different from what he expected but went on with the operation and was justified by the Supreme Court. The writer of this testified in court that Dr. Parsonette could not do otherwise, and was not culpable. Neither could he be held on a charge of technical assault.

When we operate for the cure of sterility and find conditions that will result in a mutilation, we are in a precarious predicament. The writer has many times been called to court as an expert when a doctor has been sued. Not once did the complainant have a real cause for action. Many times it is blackmail by either the patient or her counsel, and this we must fight to our last breath.

One time the writer repaired a perineum. The woman sued her doctor for the injury. The matter was presented to the court in this fashion: "If every doctor was sued whose patient had a perineal laceration, special courts in every county would be needed to look after these cases." That case also did not go to the jury, for the writer had repaired the judge's wife. Injuries of childbirth will occur in the hands of the best of us. No conscientious obstetrician will agree that there will be no injury, nor will any gynecologist guarantee a cure. However, if the obstetrician fails to recognize a complete laceration or one of the second degree, he may be found culpable. If he fails to examine his patient at a reasonable interval after labor, and another finds an overlooked pathology, the obstetrician may be called to protect himself. The worst enemy we have is the loud and bragging surgeon, or let us be charitable and say the thoughtless surgeon, who intimates that the patient's former surgeon is at fault. After a search, the writer was unable to find out what percentage of malpractice suits are caused by this thoughtlessness, but it must be great because insurance companies warn against it. The patient well understands that she cannot bring suit if she does not receive the help of the medical profession as experts. On the other hand, she is entitled to help from our profession in cases where real malpractice is shown.

In the writer's own State one is obliged to report a venereal disease in the woman. He has done so but once because he had a right to suspect the character of the woman. In his own mind this came under "confidential communication". He long ago decided not again to report such a case, as its report might draw to himself a disagreeable and just lawsuit. Suppose we told our patient that her sterility is due to gonorrheal disease and found the husband innocent of such an accusation. Under such conditions silence is golden. The question of 'confidential communication" must most commonly be one of tact. That will often enough prevent our being called to the bar of justice. Unfortunately, tact cannot be taught.

It seems to the writer that we should be held equally responsible whether our patient is a ward or a private patient. This is not always considered so. From eminent legal counsel I learn that to a private patient in a private or semi-private ward our responsibility reaches every action, whether in the sick or operating room. The responsibility for proper instruments, errors of nurses or assistants, is ours. The complainant cannot recover from the hospital, assistants or nurses when the patient is a private one. True, they sometimes sue all. In the ward the responsibility of the operator ceases, because he has no choice in appointing assistants, interns or nurses. In private home operations, the operator also shall be held entirely responsible.

It is to be hoped that we may never be held responsible for the final outcome of our gynecologic surgery, when we have done the best at our disposal. We must show that we did the best that can be done, though we must not impliedly contract to effect a cure. We may be chagrined to learn that our patients are not only no better but even worse than they were before. Serious lawsuits are thus recorded. Proof of a bad result or a mishap is in itself no evidence of negligence or lack of skill. The courts have decided, where an irreparable injury has resulted from our efforts, that we shall be held liable. A case in question was one where a closure of the cervix resulted from the use of caustics. Our judgment may have been faulty. We can hardly be held for that unless it was based on false premises. A uterus might be removed when a pregnancy existed unknown to ourselves, for there is still no absolute test or

symptom for an early pregnancy, but then there might not have been an urgency for the operation. We have been for various reasons obliged to use radium or deep radiation. It is a most dangerous and uncertain means of action. Protection is not easily obtained. The unlooked-for result of vesico-vaginal or bowel fistulas is recorded. Disturbed sexual relations by atrophic results are not unusual. Permanent sterilization or amenorrhea looms high as a possible cause for favorable suit by the patient. It will be wise to place this possibility before the patient in writing and retain a copy of the letter. The rights of the husband in disturbed sexual relations might possibly be a good cause for claim against the gynecologist. All this will rarely happen if we have learned to properly protect the patient and we ourselves apply the treatment. There will be a difference if we recommend a technician; even if he is a doctor, we shall be held accountable for his oversights. It always seemed to the writer best that radium and deep radiation be in the hands of the skilled surgeon rather than the mere technician. Again it will be wise to have a plain understanding, preferably in writing, which should go to her physician, what the treatment will be and the possible complications. Every operation has an element of danger. This should also be stated. The patient's written consent to do anything we may find necessary is always a nice precaution but does not relieve us from the charge of negligence. For this reason, also, we must never leave the patient in the hands of another doctor except with her special consent or at least with her knowledge. Written records are of particular importance where there has been an injury to the child during delivery, since suit could be brought for 23 years after the child's birth. Post-conceptive irradiation is likely to produce unhealthy individuals in 50% of the children, often with deformed limbs but mostly of microcephalic character. No case in a Court of Justice could be more damaging to the physician. Sufficient records and publication by eminent observers are available. On the other hand, pre-conceptive irradiation resulting in unhealthy children presents no definite status for compensation at present. Nevertheless, it would be wise under our present state of knowledge to warn the patient of a remote possibility of a deformed offspring. The production of serious eye troubles is also a factor. All this is a new subject for consideration, and calls for most careful thought and a possibility of a suit. We might even be held responsible, when we send a patient to an x-ray man for an opinion, for evil results from such x-ray applications. Irradiation for diagnostic purposes in pregnancies may be regarded with less danger, as suggested by our own eminent Fellows, Toombs and Findlay. Deep radiation as used by the professional abortionist or the complaisant physician is a consideration of the courts, and we must unhesitatingly condemn such practices. We can unhesitatingly say that the conclusion has generally been reached, and would hold good in a Court of Justice, that the pregnant uterus should never be subjected to radiotherapeutic measures. The writer is unaware whether any such case has as yet been brought before the Courts.

Current Events

WELFARE COMMITTEE MEETING

Trenton, N. J., June 18, 1933

A special meeting of the Welfare Committee in the Princeton Room of the Stacy-Trent Hotel was called to order by the Chairman, Dr. Schlichter, at 2.10 p. m., Sunday, June 18, with the following members present: Drs. Berkow, J. G. Coleman, Costello, Dandois, Davis, Green, Haggerty, Haussling, McBride, McMahon, Meigh, Morrison, North, Schlichter, Sewall, Sherman, Sommer, Tracy, Ulmer, Quigley, Ely, Newcomb, McGuire, Mahaffey and Kelley.

The Executive Secretary being absent (excused for absence through Chairman Schlichter by telegram, in response to a telegram from Milwaukee, where Dr. Reik had been attending the A. M. A. Convention), Dr. Morrison served as Secretary *pro tem.*

Dr. Quigley presented a copy of a letter sent to Senator Kuser urging that S. 226 be kept in committee; *Dr. Morrison* reported a conference with Senator Wolber concerning the same question; *Drs. Ely* and *Meigh* reported upon conferences with Senator Kuser and a group of osteopaths; *Dr. Tracy* reported a conference with Senator Powell; and *Dr. Kelley* reported a conference with Dr. English, representing the osteopaths as a member of their legislative committee but who disclaimed any part in the preparation of S. 226.

Dr. J. G. Coleman moved, and it was so voted, that we should continue opposition to that Bill (S. 226) and appoint a Special Committee to Confer with the Osteopaths for the purpose of securing their support for a Bill to be prepared and to provide for *a uniform law governing the licensing of any and all would-be practitioners of the healing art.*

Drs. Quigley and *Mahaffey* volunteered to be present at the Legislature on Tuesday, June 20; Drs. Sommer, North and Haggerty, to attend also on Tuesday; Drs. Morrison, Meigh, Costello and McMahon to cover all day Wednesday; Drs. Ely and Schlichter on Thursday; Drs. Coleman, Meigh and Berkow on Friday.

A discussion of S. 125 followed, and the following amendment was proposed to be presented in caucus:

"Nothing in this Act contained shall be construed to authorize the diversion of dedicated funds from one spending agency, as hereinafter defined, to another or to convert said dedicated funds into free treasury funds."

It was moved, seconded and voted that this amendment be approved. The meeting then adjourned.

Respectfully submitted,
J. B. Morrison, M.D.,
Secretary, *pro tem*

Public Relations

(The following clippings from news-papers of New York City, tell a sad but not uncommon story concerning the folly of allowing so-called Sanatoriums to practice the healing art under the cloak of religion.—Ed.)

YOUTH'S DEATH LAID TO "CULT PRACTICE"

Mercer County Prosecutor Erwin E. Marshall and Frederick Fitch of the State Department of Institutions and Agencies began today separate inves-

tigations into the death yesterday of an East Orange youth in Ten Acres Sanitarium, a Christian Science hospital in Princeton.

The victim, Charles E. Berton, 20 years old, suffered a fractured neck while bathing in Lake Hopatcong Sunday and was removed to the Princeton institution on Tuesday from his parents' bungalow at the lake. He died after, according to County Physician Charles H. Mitchell, he only had "prayer treatment".

"It is outrageous that such weird cult practices should be permitted in the heart of civilization", Dr. Mitchell said. "On all sides there were available the facilities of advanced science that could have saved his life, and yet this boy was allowed to die without medical treatment.

NEGLECT IS ASSAILED

This institution claims to be the only authorized Christian Science hospital in New Jersey. The fact is that this boy was left to die. Mrs. McDonald, the head nurse, told me that they had no history of the case, did not even so much as know what was wrong with the boy and made no effort to find out. She told me they put him to rest in bed, gave him whatever liquid nourishment he was able to swallow, and trusted in God and prayer.

That such an institution should be permitted to conduct such weird cult treatments in the midst of advanced civilization and fail to recognize the existence of advanced medical science, is beyond belief."

CULT SANITARIUM IN JERSEY BARRED

Commissioner William J. Ellis of the State Department of Institutions and Agencies suspended today the right of the Ten Acres Sanitarium, near Princeton, to accept patients.

The suspension will continue in effect, he said, until Erwin E. Marshall, County Prosecutor, completes an investigation of the death at the hospital of Charles E. Berton, 20 years old, of East Orange. Berton suffered a broken neck while bathing at Lake Hopatcong and, according to Dr. Charles H. Mitchell, the County Physician, had nothing but 'prayer treatment" by the Christian Scientists who operate the sanitarium.

Mr. Ellis said today his own investigation clearly indicated that the youth should have been sent to a general hospital for surgical aid. His admission to the sanitarium was contrary to restrictions under which it is licensed, he said.

The State restrictions, according to the Commissioner, limit the hospital to aged, infirm and mildly nervous cases and prohibit the acceptance of patients in an acute condition or in need of operations. The last inspection, made in May, showed 9 patients at the institution, he said, all of whom came within the State regulations.

The absence of Mrs. Katherine L. Barmore, President and Treasurer of the sanitarium, was responsible for the rule being violated in the Berton case, Mr. Ellis said. She is away on vacation. The Staff is made up of 5 trained nurses and the State Department requires that 2 visiting physicians be on call. One of the doctors was called only after the youth died, it was said.

The sanitarium is the only one of its kind in New Jersey, Mr. Ellis said, and the State Department does not object to it when properly conducted, since it tends to reduce the number of patients who otherwise would be committed to public institutions.

BUSINESS ETHICS

(The following news item, though tucked away on an inside page of the New York Times of Sunday, June 25, seems to us worthy of reproduction for the benefit of many Journal readers who might otherwise not see it. It is peculiarly *à propos* to some recent happenings in the business world and to the prophecy regarding future eventualities threatening our professional interests as well. Certainly the experiment being inaugurated at the moment in Washington, the surprising acquiescence of big business, and the alacrity with which industry has accepted this radical change, bid us think and *think quickly at that*, concerning a better economic arrangement of our own professional business affairs.—Ed.)

"Graft in city politics is due chiefly to the ethics of the business world", said Paul Blanshard, Executive Director of the City Affairs Committee, in an address today before the annual Summer Conference of the League for Industrial Democracy at Camp Tamiment.

Jimmy Walker was a piker in accepting stock gifts, as compared to the profits taken by some of the great banking speculators of the boom period, as revealed in the recent Senate investigation", Mr. Blanshard said. He visualized the New York of the future as a great City-State, including Jersey City, Newark, Yonkers, a large part of Connecticut and all Long Island.

"It would be organized on the basis of economic utility of interest, with all the great economic services publicly owned. * * * Even the land would be public property, leased to individual users according to a carefully worked out regional plan. Such public ownership and use of city land is absolutely essential to prevent profiteering and congestion in downtown districts. * * *

I believe that the States of the future will gradually lose their importance and that the Federal Government will be the supreme power over *nationalized industry* and great metropolitan regions. In a planned economy even city budgets must meet the approval of a national financial ministry so that the national economic development will be properly coördinated."

Norman Thomas spoke on "A National Plan for the Control of Industry Under a New Socialist Constitution", and suggested the control of nationalized industries by administrative boards of workers, technicians and consumers, with production planned by a national council.

He said that there should be only one house of Congress, with most of the members chosen to represent districts.

Mr. Thomas followed C. A. Hathaway of the Central Committee of the Communist party, who advocated the communist form of government and radical industrial reforms on the principles of that party.

CAMDEN'S DRIVE-IN THEATER

(From "Time", July 31, 1933.)

A Colosseum for movie-minded motorists has just been completed at Camden, New Jersey. In this novel experiment the audience drives into the theater and watches the show from their automobiles, which are in effect private boxes. The picture is flashed on a screen set in an asbestos stage.

The cars are parked in 7 semicircles, each ramp being higher than the one in front of it, thereby assuring an unobstructed view. The sound dis-

tribution is so excellent that the entire dialogue can be heard more than 100 yards from the screen. There are 3 shows each night, and either because of the novelty or the convenience, the Drive-In Theatre has proved very popular. More than 500 cars fit easily into the 7 ramps, and the 50-foot space between each row facilitates entrance and exit.

Time alone will tell whether unfavorable weather conditions, which take up a rather sizable part of the year in some sections of the country, will prove too great a handicap to this type of theatre. Its success also depends upon whether or not the public will be willing to exchange the intimacy of an indoor theater for the convenience of an outdoor one. In the Camden Drive-In Theater the R.C.A. Victor Company installed its newly perfected "high fidelity" sound system, like the one in New York's Radio City. Richard M. Holingshead is the inventor and manager of the theater, and he plans to build several more in the East and in California.

State Health Department

RABIES AND COMMUNICABLE DISEASES

J. Lynn Mahaffey, M.D.,

Director, State Department of Health,
Trenton, N. J.

While some persons object to activities by municipal authorities to regulate the running at large of dogs and the impounding of stray animals, greater attention must be given to such matters in order that dog bites and the threat of rabies shall not become a more serious health problem.

Since 1915 it has been required by State law that any person having knowledge of an animal affected with rabies shall notify forthwith the local board of health of the community. There had been no requirement, however, that such information received by local boards of health be forwarded to the State Health Department.

During 1931 communications were received from local health officials which indicated that although rabies was unusually prevalent in a section of the State, the State Department had no knowledge of this fact. A survey conducted through local health departments in the area revealed that an unusually large number of cases of this disease in animals had occurred, the diagnosis having been confirmed in most instances by examination at laboratories other than the State laboratory.

As an outcome of this situation, the State Department of Health passed a resolution, requiring each local board of health to notify it of each case of rabies in animals within a week of receiving such knowledge. Each local board of health was apprized of this resolution and furnished with special forms to be used in forwarding weekly reports showing the number of cases of rabies in animals reported to such board.

From the adoption of the resolution in April to June 30, 1932, the close of the State fiscal year, local boards of health reported 109 cases of rabies in animals.

By the provisions of Chapter 66, laws of 1930, physicians and others are required to report to local boards of health the names and addresses of persons bitten by a dog or other animal.

Annual reports from local boards of health for 1931 stated there had been reported to such boards during the year 7711 cases of dog bite.

The practicability of establishing in the United States a registration area for the reporting of cases of communicable diseases comparable with the registration area for births and deaths has been much discussed during recent years.

In 1931, such an area was set up under the auspices of the United States Public Health Service, the requirement for the admission of any State to the area being based upon the completeness of the reporting of certain diseases throughout the State as indicated by the proportion of reported cases to recorded deaths from these diseases. Diphtheria, measles, scarlet fever, typhoid fever and whooping cough were adopted as the basis of comparison.

New Jersey was admitted to this area at the time of its establishment, it having been shown by official records that the required standard of completeness in the reporting of the diseases named had been reached.

Communications

PLASTIC SURGERY

(A communication received from Dr. Maliniak, on behalf of the Society of Plastic and Reconstructive Surgery.)

The following resolution condemning sensational presentations of plastic surgery by irresponsible and non-representative individuals and groups was adopted by the Society of Plastic and Reconstructive Surgery at its stated meeting at the N. Y. Academy of Medicine on May 26, 1933.

Whereas, sensational stories frequently appear in lay publications concerning the cosmetic repair of the face and body with special reference to the correction of nasal malformations and the eradication of the stigma of age; and

Whereas, these stories convey the erroneous impression that plastic surgery is purely for cosmetic purposes and involves procedures that may safely be performed by lay cosmeticians in an environment that does not provide the strict asepsis and other safeguards of a hospital operating room; and

Whereas, these stories are designed to appeal to, and promote the exploitation of, unstable and often psychopathic individuals who have no genuine deformity but are overly sensitive to negligible imperfections and the changes wrought by age;

Therefore, be it resolved, that the Society of Plastic and Reconstructive Surgery take steps to inform the public:

(1) that plastic surgery is a regular surgical specialty, embracing the reconstruction of defects and malformations that interfere with normal function as well as the repair of gross cosmetic deformities;

(2) that those engaged in the practice of Plastic and Reconstructive Surgery require the same scientific and technical training as the practitioners of any other surgical specialty and are bound by the same ethics, adopted in the interests of the public, that govern all reputable physicians, and

(3) that the safe performance of even minor plastic and reconstructive procedures demands the precautions and safeguards of a first grade operating room;

And be it further resolved, that this Society con-

demn the performance of any plastic operations whatsoever by lay cosmeticians and the use of beauty shops, hotel suites and convention halls for this purpose;

And be it further resolved, that this Society warn the public of the dangers of any surgery at unqualified hands and the unreliability of sensational, self-aggrandizing publicity;

And be it further resolved, that this *Society* urge the community to recognize the social aspects of plastic and reconstructive surgery and make it available, at competent hands, to the poor as well as the rich in cases where cosmetic or functional repair is genuinely indicated.

REPORT OF THE STATE CRIPPLED CHILDREN'S COMMITTEE TO ELKS' ASSOCIATION OF NEW JERSEY FOR THE YEAR 1932

It is indeed gratifying to state that after 10 years of whole-hearted coöperation by the respective Elks' Lodges, excellent progress has been accomplished in connection with a complete program for crippled children, which resolves itself into 5 lines of endeavor: (1) finding and registering; (2) physical rehabilitation; (3) general education; (4) vocational guidance and training; (5) placement in employment.

The Elks of New Jersey are constantly endeavoring to secure for crippled children the same opportunities in life as are enjoyed by normal children. The over 13,000 crippled children in New Jersey range from those who may require only slight direction or advice to those who represent clearly defined problems of medical care, education, placement, etc. These needs in some cases may be met through the normal channel of health, education and social endeavor, while in other cases specialized care must be provided. The Elks, therefore, are endeavoring at all times to see that every crippled child in New Jersey, of whatever type, receives the kind of care best suited to his individual needs, with the result that every crippled child in need thereof known to the Elks has been offered the opportunity of examination and diagnosis.

During the infantile paralysis epidemic of last year, the Elks coöperated whole-heartedly by securing approximately 500 of those previously afflicted with infantile paralysis to volunteer to give their blood for the purpose of making serum. At present we are conducting a survey in connection with those reported as afflicted with infantile paralysis during last year's epidemic. A summary is attached of the cases investigated to date.

We are submitting herewith reports of the respective Subordinate Lodges, indicating their activities in connection with crippled children's work; also a classified list of expenditures of the respective Lodges.

In our work for crippled children, we must not lose sight of the fact that the purpose of our activities is to produce self-supporting citizens, and that the problems of the later adolescent and early adult years are more acute and less adequately provided for than those of any other age group.

The following figures, indicating the amount expended for crippled children's work by the New Jersey Elks for the past 5 years, may be of interest:

1928	$122,510.36
1929	143,450.87
1930	156,087.23
1931	185,324.94
1932	182,952.09
	$790,325.49

In addition to this amount, the respective Boards of Freeholders last year expended $94,435.35, in connection with the law recently enacted whereby each County may appropriate up to $30,000 per year for crippled children's work.

Summary of Survey Being Undertaken in Connection with Recent Paralysis Cases

975	Cases reported
118	Deaths
857	Blanks referred to the respective committees or nurses
306	Reported to date

Analysis of Those Returned

120	Reported as afflicted in some manner
158	Reported as entirely cured or no paralysis
20	Unable to locate
3	Moved to other States, but referred to proper department in respective States.
5	Died
306	

EMERGENCY RELIEF ADMINISTRATION

(A message from Dr. S. T. Snedecor)

Dear Dr. Reik: I am enclosing a copy of the plan for coöperation with the Emergency Relief Administration which we have adopted. Will you give it suitable publicity in the next issue of the Journal, if that is possible?

To the Presidents and Secretaries
of County Medical Societies:

The Medical Relief Committee of the State Society submits herewith a memorandum of an agreement entered into with the State Emergency Relief Administration which outlines the practices to be observed in taking care of Emergency Relief clients.

You will please observe that we have agreed to set up in each County a special committee, to be known as the Medical Relief Advisory Committee, to coöperate with the County Director in order that the principles set forth in this plan may be started into operation.

The Committee, therefore, requests you to take the following immediate steps:

(1) The County Society shall appoint or elect a committee, of not less than 5 members, to be known as the County Medical Relief Advisory Committee.

(2) This Committee shall immediately prepare, for submission to the County Director, a list of licensed physicians within the county who are willing to accept Emergency Relief work.

(3) The Committee shall contact the County Director of Emergency Relief, at once, to arrange a fee schedule for Emergency Relief clients.

(4) While the maximum fees of $1 for an office call, $2 for a house visit, and $25 for an obstetric patient, have been agreed upon; the rate for your individual County shall be based upon a proportion of from ½ to ⅔ of the prevailing average fees in your County.

Several parts of the plan are worthy of special attention:

Doctors shall strive to take care of these clients in the home and shall refer them to the hospital for emergency conditions only.

The method of submitting bills should be carefully studied and it should be noted that no patient shall be charged to the Emergency Relief Administration without proper authorization.

It will be necessary to inform every member of your society about the details of the plan, and it will be published in the State Society Journal (see page 593).

The Committee stands ready to assist, in any way possible, to help in organizing or to smooth-out troubles. We have promised the Emergency Relief Administration the whole-hearted coöperation of the profession.

Respectfully submitted,

Medical Relief Committee of the
Medical Society of New Jersey,
Spencer T. Snedecor, Chairman
James Fisher, Secretary

COMMITTEE MEMBERS

F. J. Quigley, President
J. B. Morrison, Secretary
W. P. Eagleton, Chairman Board of Trustees
C. H. Schlichter, Chairman Welfare Committee
James S. Green

C. C. Beling
A. C. Crowe
Frank Scammell
James Fisher
S. T. Snedecor
} Councilors

ANNUAL REPORT OF THE SOCIETY FOR THE RELIEF OF THE WIDOWS AND ORPHANS OF THE MEDICAL MEN OF NEW JERSEY

By W. D. Miningham, M.D., Secretary
Newark, N. J.

The Board of Trustees submitted its Fifty-first Annual Report; that of the year ending May 1, 1933.

We have 532 members, a gain of 28. Our Permanent Fund is $51,431.92. The income from the Permanent Fund for the year was $2546. We have donated during the year, to 12 widows of deceased members, $1160. We are sorry to report it was necessary to drop from our rolls 14 members, because of unpaid assessments; 2 have resigned, 2 have been reinstated, and 54 new members were elected. Our expenses have been $340.42, and we paid to heirs of deceased members $3987.

The 12 members called to rest from their work, where there will be no more pain or sorrow, were: Eugene Holden Goldberg, of Arlington; Wellington Campbell, of Short Hills; Frank Leslie Martine, of Newark; Emanuel D. Newman, of Newark; Emanuel Schwarz, of Newark; William L. Pyle, of Jersey City; Henry Bayard Whitehorne, of Caldwell; Lazarre Weiss, of Newark; Martin W. Reddan, of Trenton; Cuthbert Wigg, of Boonton; I. D. Williams, of New York; and William G. Schauffler, of Princeton.

Of those, 8 died from circulatory troubles, coronary thrombosis or cerebral hemorrhage; and 4 died from cancer.

It will be 3 years, on May 11, since our valued and life-long Secretary, Dr. Charles Day Bennett, died. We wish to quote the words he wrote in his report of 1929. "While we deeply regret the passing of our friends by death, we are not disposed to look upon such incidents as losses, but rather as moral gains, inasmuch as our Society, to that extent, at least, has been fulfilling its purpose and justifying its existence by being of assistance to the families of our departed members. It is the feeling of your Board that membership in this Society should be looked upon as affording opportunities to aid those needing assistance, and this view should be a broad one, covering not only one's own family, but the families of all other members. It never has been the aim of your Society to enrich anyone, but rather by small and, if necessary, repeated contributions, to aid our family groups in meeting financial emergencies, to which, it should never be forgotten, we are liable. It is from this point of view that we especially regret the cancellation of membership by resignation or delinquency. Such action constitutes an actual loss and we can only believe that in such cases the retiring member has completely failed to grasp the real purpose, and the high aims of a Society whose true intent it is, to benefit others."

During the past year, the families of at least 2 of our deceased members have notified the Treasurer that they were very much surprised to learn that the benefit they were to receive was not $1000, which amount the decedent had always told them they would receive at his death. It is quite evident that many of the members have never read the annual reports, which are sent to each member yearly, nor have they "perused" the Constitution and By-Laws to the extent of learning just what amount might be expected.

Being somewhat concerned by this condition of affairs, the Trustees feel that they should take this opportunity to advise the members that the amount of the benefit to be paid to heirs, is 75% of the amount collected by the Treasurer upon the death of a member. As our membership at present is 532, we could hardly pay more than $399, except for the fact that a few members joined the society after they were 50 or 60 years of age, and therefore pay $2 or $3 respectively, and bring the benefit to approximately $415.

The Board of Trustees is extremely grateful to the members of the Society for the confidence placed in it; allowing it to govern the affairs of the Society. However, the Board feels that it is a matter of duty as well as interest for members to attend the Annual Meeting, invitations to which are mailed to every member. The membership attendance at this meeting for the past 20 years has averaged less than 30 out of a membership of more than 500.

We wish to express our appreciation to Dr. Charles H. Schlichter, of Elizabeth, N. J., who secured 30 new members during the past year.

We have had applications for aid from widows whose husbands had never been members of our Society. Our By-Laws do not permit us to use the funds in that manner.

We hear so many tales of woe from needy widows that it is fairly easy for the Trustees to be merciful; but, if a thousand more tongues could tell of the Society, would not more doctors join this Society, so that we could be of greater service?

We share our mutual woes,
Our mutual burdens bear,
And often for each other flows
The sympathizing tear;
Our fears, our hopes, our aims are one,
Our comforts and our cares.

SUMMARY REPORT OF THE TREASURER

Receipts

Balance on hand May 1, 1932	$2032.99	
Amount received from assessments, initiation fees and interest	5406.30	
		$7439.29

Disbursements

Claims Paid	$3987.00	
Transferred to Permanent Fund	1035.92	
Incidental expenses, printing, postage, bonds for officers, etc.	340.42	
		$5363.34
Balance on hand May 1, 1933		$2075.95

REPORT OF THE MEDICAL ADVISORY COMMITTEE OF THE MEDICAL SOCIETY OF NEW JERSEY

Plan of Organization and Function

Organization. In accordance with resolutions passed by the Medical Society of New Jersey, and as agreed to by Col. Joseph H. Bigley, representing the Emergency Relief Administration, Mr. John Colt, State Director of Emergency Relief, has appointed the following physicians as members of the State of New Jersey Emergency Relief Administration Medical Advisory Committee:

Drs. C. H. Schlichter, 556 N. Broad St., Elizabeth; Christopher C. Beling, 109 Clinton Ave., Newark; and S. T. Snedecor, Hackensack (representing the Medical Relief Committee of the Medical Society of New Jersey).

Function. (1) This Committee shall meet with designated officials of the Emergency Relief Administration to formulate plans; to consider, jointly, problems, questions and issues involving the interests of the medical profession; to consider complaints; and, to maintain a liaison between the Emergency Relief Administration and the medical profession.

(2) This Committee shall aid in the interpretation of these policies to local medical societies, physicians, and the public at large.

(3) This Committee shall aid in the organization of County Medical Advisory Committees to consult with the County Directors of Emergency Relief.

State of New Jersey
Emergency Relief Administration
MEDICAL RELIEF POLICIES

Relations with Clients and Physicians

(1) Preservation of the personal relationship between the doctor and patient shall be held paramount.

(2) Medical relief shall be supplied by individual physicians, preferably by the patient's own or previous physician, which shall insure free choice of physician by clients. Free choice of hospitalization in any accredited hospital shall be permitted.

(3) A uniform procedure for authorization of medical care shall be established for each county. This procedure should not be in conflict with the following requirements:

(4) All authorizations for medical care shall be issued in writing on the regular Relief Order Blanks, with the exception that telephone authorizations should be immediately followed by such a written order. This order authorizes the doctor to provide medical care for a period not to exceed 2 weeks or involving not more than 10 visits or representing an expenditure of not more than $20. Medical care for more than 2 weeks shall be based only on a written renewal of the original order, such renewal not to be issued until after a reinvestigation of the case in the home. The Emergency Relief Administration shall not suggest the name of any particular physician, but may provide a roster of physicians.

(5) Medical care for prolonged illnesses, such as arthritis (chronic), asthma, and chronic heart disease, shall be authorized on an individual basis and, in general, shall be limited to not more than 1 visit per week over a period not exceeding 3 months. In those instances where more frequent visits seem to be indicated for a short period, additional authorization for such service should be obtained.

(6) Authorization for emergency service rendered by a family physician may be provided, if the physician reports to the Relief Administration within 48 hours the name and address of the sick indigent person, and the occasion for the emergency visit. Such cases are to be considered as exceptional and the approval, if given, should be conditioned upon the acceptance by the Emergency Relief Administration of the indigency of the patient to whom such emergency service is given.

(7) The Emergency Relief Administration may authorize payment for medical care as a special or single phase of relief to a family or individual.

(8) The Emergency Relief Administration shall not pay physicians for work in clinics; nor shall it pay hospitals for admission clinic charges. However, this Administration may pay for unusual extra charges in connection with service to clinic patients, such as expensive x-ray service or unusually involved laboratory work, but only when essential in the treatment of emergent patients.

(9) The physician shall decide whether the patient requires hospitalization but, except in serious emergency, the Emergency Relief Administration shall be notified sufficiently in advance of admission to permit it to establish the propriety of accepting public responsibility for hospital charges.

(10) Operations shall be certified for medical or surgical emergency conditions only; so-called elective operations shall not be performed on relief patients unable to meet their hospital and doctor bills.

(11) Only regularly licensed doctors of medicine shall be authorized to treat patients. This clause shall not, however, interfere with necessary treatment which may be performed by registered visiting nurses, under medical direction and supervision. It shall not be the policy of the Emergency Relief Administration to substitute midwives for physicians in obstetric cases.

Remuneration Program

(1) The Emergency Relief Administration will pay for authorized medical care at a rate not to exceed $2 for each call and $1 for office visits.

(2) The Emergency Relief Administration will pay for authorized obstetric service in the home, at a rate not to exceed $25; which shall include charges for delivery, a minimum of 3 pre-natal office visits, and the necessary post-natal care. Details of these services shall be submitted with the bill.

(3) A schedule of rates at which doctors may be reimbursed by the Emergency Relief Adminis-

tration for services rendered to patients of any given County will be set up by the County Emergency Relief office. These rates shall be established by the County Medical Society through its Medical Relief Committee in conference with the County Emergency Relief Director. These rates as established in each County shall be effective subject to the approval of the Medical Relief Committee of the Medical Society of New Jersey and the State Headquarters of the New Jersey Emergency Relief Administration.

Submitting of Bills

(1) Monthly bills shall be rendered by the physicians to each municipality from which authorization to provide medical attention at public expense has been received. Inasmuch as bills are to be charged against the calendar month in which the medical care was *authorized,* 2 bills are to be furnished: (a) One to cover charges for care rendered to patients whose total course of treatment was completed during 1 calendar month; (b) the other to cover charges for care of patients whose course of treatment started in the previous calendar month and ended in the current month.

Each bill shall list the number of patients, the number of visits made to each of these patients, and the total charges. Authorization for the treatment of each of these shall support each bill and these authorizations shall cover all charges on the bill for which payment is sought. Since the charges for each patient must be accompanied by the authorization for these charges (Form ERA-A. 18), bills will not be submitted for any patient until the course of treatment is completed or the extent of the authorization, as shown in paragraph 4 of the "Relations with clients and physicians", is exhausted.

(2) Doctors should be advised that they must procure the signature of the patient or the head of the patient's family on all authorizations (Form ERA-A. 18), as auditors will not pass bills unless the signature of the client or the head of his family is so affixed.

(3) The individual physician shall have the right of appeal from "A" Grant communities to the County Directors of Emergency Relief for payment of his bills.

Drugs

(1) *Drugs.* All prescriptions for necessary drugs and medicines shall be filled from the National Formulary of U. S. Pharmacopeia or from a Hospital Formulary. Payments for proprietary remedies shall not be reimbursed. (2) Physicians should use the least expensive drugs where possible. If expensive drugs are considered essential a written order should be obtained.

Relations with Medical Societies

(1) A medical advisory committee shall be appointed by the State Director to assist in formulating plans to make these proposals effective. It shall be the joint responsibility of the Emergency Relief Administration and the Medical Society of New Jersey, that the plans evolved be mutually acceptable to both sides.

(2) The Medical Society enters into this plan for a period of 1 year and shall have the power to designate when coöperation with the Emergency Relief Administration shall cease.

(3) Future changes in policy shall be agreed upon mutually.

(4) In each County the County Medical Society shall appoint a Medical Relief Committee to advise the County Director of Emergency Relief concerning medical problems.

(5) The same relationship shall pertain to the County Medical Relief Committee and the County Director of Emergency Relief, as exists between the State Director of Emergency Relief and the State Medical Relief Committee. All matters in dispute shall be considered jointly by the County Director of Emergency Relief and the County Medical Relief Committee.

(6) This Committee shall supply to the County Relief Administration an approved list of duly qualified and regularly licensed physicians residing within the County who desire to accept relief patents.

(7) The Committee shall have power to discipline physicians and to request removal from approved list. Appeals from the decision of County Medical Relief Committees may be taken to the State Committee by individual physicians excluded or removed from the list of approved physicians.

Relations with Other Health Agencies

The Administration and its coöperating medical committees shall be zealous to provide the best medical care and to coöperate with other health organizations, particularly hospitals and agencies providing nursing service to the indigent sick in their homes.

NEW TYPE POST-GRADUATE COURSES

(A letter from Stanley Nichols, M.D., Chairman, for New Jersey, of the Academy of Pediatrics.)

Dear Dr. Reik: As Chairman of the New Jersey Section of the American Academy of Pediatrics, it is one of my duties to help make available to the physicians of New Jersey modern pediatric knowledge, in addition to the splendid courses offered by our State Medical Society and Rutgers University Extension Courses. The New York Post-Graduate Pediatric Department of Columbia University, is offering *a new type of course* for physicians who can give 1 day a week for 9 weeks to the improvement of their pediatric knowledge. It is particularly designed for the needs of the general practitioner and has been approved by Dr. Cosgrove, personally, Chairman of the Committee on Post-Graduate Education for our State Society.

Would you be so kind as to call the attention of members of the State Society, in the August or September Journal, to this added facility for bringing pediatric knowledge up-to-date.

I am very anxious that this new experiment, of giving 1 day a week for a few weeks to post-graduate study shall succeed. If it does succeed, it will lead to a simple method of post-graduate instruction for practicing physicians who reside within 50 miles of the several medical schools in the United States; and I know that you will be interested in the idea.

THE GENERAL PRACTITIONER

(It is with a great deal of pleasure that we publish the following comments upon *state medicine,* written to us quite recently in a letter by Mrs. Marcy, of Cape May, widow of a former colleague, the late Victor M. D. Marcy. Incidentally, this letter sprang, we doubt not, out of a sense of appreciation of having been held in contact, after his departure, with the profession; a definite proof, had any been necessary, that continuing the

Journal to the bereft home was a good and wise procedure to have established.—Ed.)

Some of the articles published in favor of *State*, or shall we say *Communistic*, control of the practice of medicine, seem to argue well, but, just consider it from the stand-point of the really conscientious general practitioner.

It would seem that one of the greatest objections to *State Control* or even *Group Medicine*, might be that—young men, intellectually superior, with high ideals of personal service, and who also have great personal ambition, might not be attracted to the medical profession under such restrictions as an outlet for all these attributes of character and achievement and also as a means by which to live in such manner as a man of superior mental attainments has a right to expect.

The next great objection would be, I think, the personal equation. Can any reduced fee to the patient possibly supply the personal element which the loved family physician now gives?

While it is true that we have fewer "family physicians" than formerly, still, we do have them, and I have intimate knowledge of the loving services of one "general practitioner" who for 25 years lived and worked in one community. This span of years was just long enough for him to have cared for his first "labor cases" and to follow those same children through years with all their ailments until he began to be called upon by those same patients, but now grown up and bearing their first children.

In all *their troubles* he met every emergency with them. With the nearest study center and nurses directory nearly 100 miles distant, consultants and nurses were called in every emergency; sometimes to arrive after a danger period had lessened.

I have in mind an instance where an obstetrician with a nurse arrived after the baby was not only safely delivered by the family physician but also, washed by him and ready to be turned over to the nurse on her arrival. The astonishment of the obstetrician was amusing and in telling me of the incident he remarked: "The best physician in the world is the old fashioned family doctor".

High fees do exist, we all know it. There are a great many men practicing medicine, and no doubt some of them are selfish; but, in the main, I believe the opposite to be true. The same family physician of whom I write, once called to his aid a teacher of medicine from one of our largest Medical Schools to see the small daughter of a very poor and ignorant man. The name of the teacher meant nothing to him, he was just a "strange doctor". I was present when the family physician told the consultant to fix his fee at $15. His usual fee for such a patient, at such a distance, might have been $100. I was also present when the family doctor told the father he wanted him to have $15 in his pocket to give to the "strange doctor" before he left the house. I also happened to know that the family physician loaned the father that $15 which, of course, the "consultant" never knew.

This beloved physician has gone to his reward; a man of high ideals, who loved mankind and therefore loved to alleviate suffering; a man who "lay down his life for his friends" and his friends were legion; a man who found his greatest compensation in the satisfaction from his work and the love of the people in the community in which he lived, and where since his death his name is revered.

State Medicine, Group Medicine, any concerted control, may bring down fees, but how paradoxical—at what a price!

Helen Marcy,
115 Ocean St.,
Cape May, N. J.

In Lighter Vein

Why Worry?

"Do you keep animal crackers?"

"No, but we have some very nice dog biscuits."—Boston Transcript.

Teeth on Edge

Second-hand Car Salesman (on trial ground)—"This car is sound in every part."

Prospective Buyer—"So I hear."—Montreal Star.

Coinage of the Brain

Heard in Passing—"A lot of laymen have queer ideas about banking."

"So have a lot of bankers."—Buffalo Evening News.

No Secrets From Him

"Did you hear Erica is marrying her X-ray specialist?"

"Well, she's lucky. Nobody else could ever see anything in her."—Washington Labor.

Educational Limitations

"How soon shall I know anything after I come out of the anesthetic?"

"Well, that's expecting a lot from an anesthetic."—Boy's Life.

Bank Directors Beware

"When old telephone directors are collected they are torn in two lengthwise, then chopped into small bits in a powerful machine."—Boston Transcript.

Ouch!

And it's our opinion that banking in this country will never be safe until somebody invents a burglar alarm that will ring every time the directors are in session.—Judge.

One-Track Mind

The attorney shook his head.

"My dear man," he said, "there are hundreds of ways of making money, but only one that's honest."

The banker looked puzzled.

"What's that?" he asked.

"Ah", smiled the other, "I thought you wouldn't know."—Answers.

Defying the Earthquake

"See if you can laugh that off," said the fat man's wife as she wired a button on his vest.—Boys' Life.

Hopes It's Nothing Trivial

"Ike" Pritchard is home Tuesday with sinus trouble, something like Kenneth Yost had. He fell on the floor at Gothenburg when in a basketball game and gave his head an awful bump. It causes some worry to the folks at home. We are hoping that it does not prove only a temporary injury.—Sumner (Neb.) paper.

Woman's Auxiliary

PREVENTION OF HAY FEVER

On more than one occasion, when considering possible tasks for the Auxiliaries, the Editor has suggested, among other things, following the example of one of the Southern State Medical Society Auxiliaries which rendered excellent service in the interest of hay fever sufferers. It is in the line of preventive medicine and is a worthy project. The following news item, bearing there-on, was clipped from the Bronxville Review, of July 22, 1933.

Destruction of the rag weed is advocated by the Civics Department of the Bronxville Women's Club as an effective means of combating hay fever. Owners of unimproved property are urged to see that it is cleared of the noxious weed which has feathery leaves and often grows to a height of several feet. The Civics Department also asks that citizens who notice rag weed growing on unoccupied property report its location to Village Clerk C. Leary who will communicate with the owner. Already several plots have been cleared up in this manner, the department reports.

County Society Reports

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The Society met at Ivy Manor, the Country Sanatorium of Dr. Reba Lloyd. Members of the component societies have frequently enjoyed the hospitality of Dr. Lloyd, and the beautiful location of the Manor, and this time a large number assembled to enjoy the well-prepared and interesting program.

The extended and interesting report of the State Welfare Committee was read by our Secretary, Dr. Lyon. The thorough work of the Committee, with its findings and conclusions, should have the careful consideration of every member in the Society and every physician in the State. The basic principles are correct, but inability or lack of cooperation on the part of the individual doctor and the misinterpretation of a large part of the public as to the motives of the doctor, make it difficult of accomplishment. The present crisis shows that neither doctors nor patients can get along without State aid, and in many instances, the State program must be adhered to; the stupendous burden to be carried must be borne by the State and of necessity under State supervision.

Dr. H. G. Miller disclosed an attitude of opposition held by certain members of the State Society toward Dr. Reik, the Editor of our Journal, and he introduced a resolution of confidence in Dr. Reik and a demand for his retention, which was unanimously passed. After the planned work of Mrs. Taneyhill and Dr. Nichols for the State was described, a motion was made to invite them to address this Society at some subsequent meeting.

Dr. J. B. Morrison spoke on various phases of the State Society's work and referred especially to the Post-graduate work, which, owing to the depression, it had seemed it might be impossible to carry on. The President of Rutgers University was appealed to personally and the value of the work explained, whereupon his coöperation with the State Society had made possible during the past year the presentation of one of the best programs at lesser fees than formerly.

Dr. A. M. Ornsteen, of Philadelphia, delivered an interesting and illustrated lecture on "Neurology of Childhood". Certain features apply to childhood only because of the areas involved. Sleeping sickness with its progressive manifestation and sequels, was fully illustrated and explained. A child who developed bizarre motor symptoms after a third injection of scarlet fever antitoxin, was found to have been excited by the nervous actions of its mother during the injections. When the child was moved to quiet surroundings, the movements immediately stopped. A patient with symptoms simulating intestinal parasites was later found to have had a cerebellar tumor; a patient with Jacksonian-like convulsions was later shown to be a case of masturbation brought on by an injudicious nurse. Postdiphtheritic complication involving all the muscles of the back was shown. At first the recovery was very doubtful, but eventually the muscles were restored to nearly normal functions. Many cases of diphtheria are not recognized until the paralytic symptoms are seen. Cultures demonstrate that the patient has been a diphtheria carrier.

Congenital trauma fills a large place as the cause of malfunctions in later life; normal deliveries may have nerve involvement; instrumental deliveries are fruitful causes of pressure and hemorrhagic damage.

Dr. E. S. Corson showed x-ray pictures of a patient with acromegaly. There was increase in the size of all the bones; and an adenoma at the base of the brain was pointed out.

A patient with Paget's disease, presented at the same place a few years before, was again presented to show the changes that had taken place in the interim. The bones of both legs had markedly increased in size, with weakening and bowing; the body bends forward so that a support must be used to maintain the equilibrium.

A young girl of 13 was shown with a 3 in. shortening of right arm; x-rays showed marked atrophy of the bones of the shoulder joint and a slight bending of the humerus; a history of traumatism of the shoulder in the region of the brachial plexus was elicted.

After adjournment of the meeting, Dr. Lloyd invited the guests into the dining room where they were received by members of the family. Everybody stayed until they had finished the bounteous meal prepared with vegetables and chickens from the sanatorium farm.

MONMOUTH COUNTY

R. A. MacKenzie, M.D., Reporter

The regular monthly meeting of the Monmouth County Medical Society was held on Tuesday evening, June 27, at the Monmouth Memorial Hospital, Long Branch, with President Robert E. Watkins presiding.

The Report of the Executive Committee meeting of June 19, which was accepted, drew attention to the fact that Monmouth County will be well represented in the State Society for the ensuing year, as Dr. William G. Herrman was reëlected to the Board of Trustees for 3 years; Dr. Stanley Nichols

appointed Chairman of the Public Health Committee; Dr. Robert MacKenzie made a member of the Maternal Welfare Committee; and Dr. James A. Fisher will continue as Councilor of the Fourth District. The Committee announced also a change in the terminology of officers, making provision for a President-Elect and 2 Vice-Presidents instead of 3 Vice-Presidents, as of yore.

Dr. Albert Schmidt, of Manasquan, was elected to membership.

A new Nominating Committee, consisting of Drs. James A. Fisher, William K. Campbell and John C. Clayton, was elected.

The Society was honored by the presence of the new President of the State Medical Society, Dr. Frederic J. Quigley, of Union City, who spoke on the "Plans of the New Administration".

Dr. Christopher Beling, of Newark, gave a very interesting talk on "The Pituitary Gland from its Physiologic and Clinical Aspects", and that subject was discussed by Drs. Grossman, Herrman, and Gordon.

Dr. Joseph Wiener, of Asbury Park, read an original paper, entitled "Peri-arteritis Nodosa", at the meeting of the American Therapeutic Society, in Milwaukee, in June. During the sessions of that Society Dr. Wiener was elected to membership.

Dr. Carlos A. Pons, Pathologist to the Monmouth Memorial Hospital, Long Branch, and the Fitkin Memorial Hospital, in Asbury Park, was elected a Fellow of the American Society of Clinical Pathology at its June meeting in Chicago.

Dr. Robert A. MacKenzie, of Asbury Park, was granted a specialist's qualification Certificate by the American Board of Obstetrics and Gynecology, following examination before this Board held during the Milwaukee meetings of the American Medical Association.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the Morris County Medical Society was held the evening of Friday, May 26, at the State Hospital at Greystone Park. President Pinckney presided over an attendance of about 30 members. No routine business was transacted and the evening was given over exclusively to scientific discourse.

The speaker of the evening was Dr. Robert L. Levy, Cardiologist of the Rockefeller Institute, of New York City, whose subject was: "Modern Conceptions of Heart Disease and Its Treatment."

Responding to the President's introduction, Dr. Levy expressed his appreciation of being invited to be present, and said that he should be the one to express thanks to those who had come on a rather warm Summer evening to hear anyone speak.

Dr. Levy said that if only because of the number of individuals afflicted, heart disease has become an important part of medical practice; that, as most medical men know, approximately 2% of the population of this country suffer from one form or another of cardiac ailment. He reminded us that there has been a great deal published concerning the *rising tide of heart disease* and he said it is true, according to vital statistics, that heart disease, at present, is the *leading cause of death*, and is now more important as a cause of death than tuberculosis or cancer. Physicians must look below the surface for the cause of those statistics. In the first place, there has been in this country for the past 30 years a significant fall in the death rate from infectious diseases and individuals who formerly would have died of such infections survive that ordeal and die of something else. Diphtheria and typhoid fever are practically unknown now because of sanitary measures, immunization and vaccinations that have been practiced. The lowered morbidity and mortality rates of infectious disease, and survival to ages at which they die of something else contributes to the comparatively higher statistics of heart disease.

The speaker discussed some very interesting results of various surveys made, and drew from his own experiences in a way that contributed to hold the interested attention of his audience. In treatment, he stressed the importance of complete rest and the value of digitalis, which drug he did not at all favor in liquid form but emphasized the use of its standardized, uniform preparation in tablet form.

Discussion followed by Drs. Lathrope, Young, Teskey, Teller, Gilbertson, Haven, Christian and Rubin.

SALEM COUNTY

Fifth Councilor District Meeting

John S. Irvin, M.D., Reporter

The Annual Fifth Councilor District Meeting was held at the Salem Country Club, Tuesday afternoon, May 16, and after an excellent *Planked Shad Dinner* the meeting was opened by Dr. William T. Hilliard, of the Salem County Society, who introduced: Drs. Aldrich C. Crowe, Councilor of the Fifth District; A. Haines Lippincott, President; Frederic J. Quigley, First Vice-President; and Marcus W. Newcomb, Third Vice-President, of the State Medical Society. He introduced also Dr. Walt P. Conaway, Past-President, and Dr. Henry O. Reik, Editor and Executive Secretary of the State Society; and Dr. Allen Corson, President of the State Homeopathic Society. Each of these gentlemen spoke a few words of greeting.

The first Guest Speaker of the day's program was Dr. Francis A. Faught, whose topic was—"Medical Economics".

The Second Guest Speaker was Dr. L. Waller Deichler, of Philadelphia, who presented an excellent discourse on the "Relation of the Out-Patient Department to Medical Economics". (Both papers appear in this Journal.)

Obituaries

STEWART, William Blair, M.D., of Atlantic City, died suddenly on July 11, on his way home from a professional call at one of the hotels; falling on the Boardwalk and expiring before medical assistance could be procured.

Dr. Stewart was of Scotch-Irish descent. His father, William Graham Stewart, and his grandfather, Thomas Stewart, were both physicians. He was born on March 6, 1867, at Middle Spring, Pa. Later the family moved to Newville, which remained his home for many years and to which he loved to return twice each year in later life. He entered Dickinson College, receiving his Ph. B. degree in 1887 and M.A. degree subsequently. In 1890 he graduated, with highest honors, from the Medico-Chirurgical College of Philadelphia, where he later became Assistant Professor of Materia Medica and Physiologic Action of Drugs (1893-1898).

In August 1894 he moved to Atlantic City as a

permanent resident, assisting Dr. Boardman Reed at first, and taking over his property at the corner of North Carolina and Pacific Avenues when Dr. Reed retired from practice. Here he brought his bride, Florence Elizabeth Giffin, in 1897; here were born their children (Walter Blair Stewart in 1898 and Sloan Giffin Stewart in 1901, both now practicing physicians); and near here he died on July 11, 1933, at the age of 66.

He was President of the Atlantic City Board of Trade, a Director of the Chamber of Commerce and of the Y. M. C. A., member of the Board of Education, President of the Board of Trustees of the First Presbyterian Church for many years, a Republican, a Mason since youth, having for many years held the 32nd degree, and a Rotarian, with a perfect attendance record for 8 years.



WILLIAM BLAIR STEWART, M.D.

To quote from an Editorial in the *Atlantic City Press*: "Dr. W. Blair Stewart, who died this week, should be long remembered for his upstanding citizenship no less than his high professional rating and worth. Always a conservative, of sound and practical judgment, he was ever to be found working diligently for projects which meant worthwhile progress for Atlantic City, against projects which smelled of malodorous politics or other civically-destructive influences."

His medical record needs little elaboration. He was author of a "Synopsis of the Practice of Medicine" in his earlier years and was a frequent contributor to medical journals. He was regular in his attendance at medical meetings, local, state and national. For many years he was surgeon to the Atlantic City Hospital, but later, feeling an increasing fondness for internal medicine, he gave up major surgery and worked solely as internist. He was a Past-President of the Atlantic County Medical Society. He was always active in the affairs of the New Jersey State Medical Society, and was Chairman of the Committee on Scientific work which had constructed the Program for the 167th Annual Meeting of the State Society, in Atlantic City, June 6-9, 1933. In 1907-1908 he was Fourth Vice-President of the American Medical Association, and from 1927 to 1930 a member of the House of Delegates. He had been a Fellow of the American College of Physicians since 1916, Chairman of its Board of Governors, and member of the Board of Regents.

His outstanding contribution to public health work, which received national recognition at the time (in the late nineties), was the detection of various sources of typhoid fever in Atlantic City and their complete eradication.

Although, in his final year of life, attacks of coronary disease and myocarditis became increasingly annoying, he dreaded the prospect of a life of invalidism, insisting rather on remaining in harness until the end, which came suddenly, as he would have had it.

At the funeral of Dr. Stewart, the oration by his friend and spiritual guide, Rev. Henry Merle Mellen, D.D., Minister of the First Presbyterian Church, Atlantic City, was so unusually appropriate that we present portions of it here:

'The solemn auspices under which we gather this day, with echoes of the old, old promises of The Book lingering in our spiritual being, find us bewildered with 'all the tender pathos of the Here and the Hereafter'. The physician who lies before us in the majesty of death speaks to us from the shadow of life's final summaries, and bids us ponder the values of positive service in the light of immortality. We cannot and we dare not visualize with definiteness the far swept shore of this man's abiding influence, but we may linger beside certain realities that cannot fail here or anywhere. Death ends many human processes, but it also lends splendor to values and ideals that are deathless, the which we all eagerly pursue, and yet realize so scantily. In this respect, the fine recent editorial by the late George T. Dowling, D.D., in 'The Churchman' is altogether pertinent here:

> 'If, when at last, the night shall begin to fall, and the things which now seem so important shall all have been left behind and the Master's voice shall be heard saying: "The day is done. The work is finished. Lay down the burden. It will soon be time to go to sleep."
>
> If, in that hour, I can remember that among the toilers in the field, I have tried to do a man's part; that when the sun was withering I have not shirked my stint; that when another has grown weary, I have tried to speak a word of hope, and to lend a hand which would help and never hinder;
>
> If I can feel that in my work I have known how to sing, and because of that, have taught others to sing, too; if I can know that in my heart I have cherished hatred toward no human being, but, seeking to be like Him, have tried to forgive as I would wish to be forgiven, and to judge charitably of others' feelings as I would want them to judge of mine; then, whatever mistakes may have been made, I can lie down and sleep as peacefully as the little child at evening time, who, with the mother's touch upon its hand, passes into slumber, knowing that all is well; that there is One watching beside me, who "neither slumbers nor sleeps", and that when I shall awaken it will be to find myself in the Old Home, surrounded by those whom I have learned to love, and that it shall be morning.' "

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SUGGEST COUNCIL IN MONTCLAIR TO CO-ORDINATE HEALTH WORK

(Newark Evening News, May 22)

Dr. Leverett D. Bristol, of Montclair, Health Director of the American Telephone & Telegraph Co., speaking at a meeting of community leaders sponsored by the Montclair Community Chest, declared there is need for the creation of a Montclair Health Council as a planning and coördinating agency. Dr. Bristol formerly was Commissioner of Health of Maine.

Such a group, he suggested, should have no administrative or executive functions, and might be organized as a subcouncil or committee of the present Council of Social Agencies or as a separate body.

The executive officer and one board member of each of the public and private health agencies and town institutions including the Health Department, hospitals and the local organization of physicians and dentists under an alternating chairmanship, would make up the proposed council.

Dr. Bristol said that at present the services of the Health Department, the school health activities, the Public Health Nursing Work, the tuberculosis projects, hospital programs and the various aspects of preventive medicine carried on by private doctors are more or less uncoördinated and planned without reference to the sum total of health needs.

Health conservation should be the chief aim, the speaker declared.

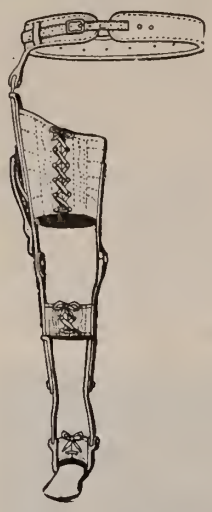
Dr. Bristol outlined the elements of an adequate community health program and stated that at present each of the various agencies and institutions is doing a commendable work so far as possible without more integration with the plans and work of the other agencies.

The speaker indicated that the public tax-supported agency is bound by laws, regulations, defined duties and powers and is interested primarily in mass or group problems and protection.

The private health agency, he said, is supported largely by voluntary contributions and may do much needed pioneer work.

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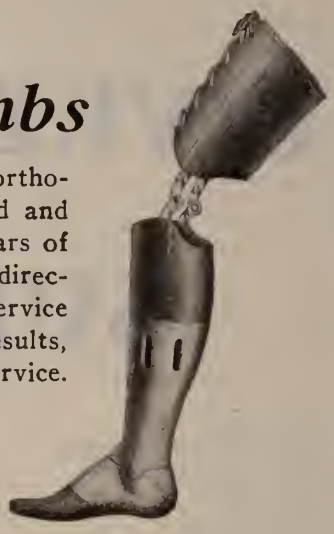
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GROCERS' SALE OF DRUGS IS FOUGHT

(New York Times, June 13)

The battle of pharmacists to ban the sale of drugs in grocery stores gathers force, according to The American Druggist. The fight is being carried by the retail druggists to the State Legislatures on the grounds that public health requires that the seller of drugs should be trained in their use and sale, and that the existing drug stores in this country are more than enough to take care of the public's need for pharmaceutical products. Dr. Robert P. Fischelis, Secretary of the New Jersey Board of Pharmacy, states in the magazine: "When a grocer stocks a line of drugs and offers them for sale to the public, he is embarking upon a venture which may be unlawful and at best is apt to prove harmful to that section of the public which is induced to purchase drugs from unqualified persons."

AMERICAN MEDICINE IN ASIA

(Newark Evening News, June 9)

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Continued on Page XXIV.

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Continued from Page XXI.

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THE JOURNAL

OF THE

Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange New Jersey, under Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 9 Orange, N. J., September, 1933 Subscription, $3.00 Per Year Single Copies, 30 Cents

N.Y. ACADEMY OF MEDICINE SEP 27 1933 LIBRARY

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PRACTICING FIFTY-FIVE YEARS

(Newark Evening News)

Dr. Thomas W. Harvey, of Orange, dean of physicians in the Oranges, who was seriously ill several months ago, is building up his strength and enjoying traveling. The physician, who has been ministering to patients 55 years, spent most of the Spring in the South, and now is on a trip to Labrador. He expects to resume practice the end of this month.

Dr. Harvey, besides having a leading part in the advancement of his profession and health promotion work in the suburbs, has taken an active part in civics, having been President of the New England Society of Orange, the oldest civic organization in the Oranges. Throughout his career he has been associated with the Orange Memorial Hospital. He was once Chief of the institution's Staff, and was also responsible for its Training School for Nurses, which has a country-wide reputation. The first nurse was trained under his supervision in 1882.

Dr. Harvey is one of the oldest living Princeton graduates. One of his treasured trophies is a gold football given him for managing the first Tiger eleven that clashed with Yale in 1873. The football was somewhat delayed in reaching his watch chain as it was not presented until the 1923 reunion of his class.



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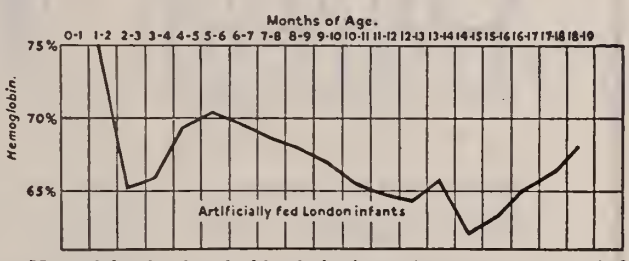
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Preventing NUTRITIONAL ANEMIA *in Infants through a Normal Dietary Regimen*

NUTRITIONAL anemia was present in 45% of the breast-fed and 51% of the bottle-fed in a group of more than 1,000 infants studied by Mackay.[1] Although this anemia was of mild degree, *it was sufficient approximately to double the morbidity among the artificially fed.*



Hemoglobin level in the blood of infants of various ages. Note fall in hemoglobin, which is closely parallel to that of diminishing iron reserve in liver of average infant. Chart adapted from Mackay.[1]

Anemia Prevalent

Commenting on this work, the British Advisory Committee on Nutrition writes, "This form of anaemia is prevalent among infants, especially those living under conditions of city life, and is attributed to a deficiency of available iron and possibly also of copper. Its most important feature is susceptibility to infection, particularly a liability to colds, otorrhoea, bronchitis, and enteritis, and a tendency for infections to become chronic."[2]

Iron, incorporated in powdered milk, should be given as a routine to bottle-fed infants, according to the recommendations of this committee in a report to the Ministry of Health.

Milk Deficient in Iron

Stored in the liver of the full-term infant is a supply of iron and copper theoretically sufficient for the first six months of life. But actually the reserve is subject to wide variation, probably because of (except in the case of prematures and twins) variations in the iron content of the mother's diet during pregnancy. Hill, for example, says, "If the mother is anemic herself, or if she has eaten little iron-containing food during the last months of pregnancy, her offspring is born with an insufficient iron deposit. . . ."[3]

	IRON	COPPER
Cow's Milk, 14 oz.	1.01 mg.	0.166 mg.
Dextri-Maltose with Vitamin B, 1 oz.	2.40	0.570
	3.41	0.736
Daily Requirement*	3.11	"traces"

It is generally agreed that breast milk and particularly cow's milk are markedly deficient in iron and copper. But when 1 oz. of Dextri-Maltose with Vitamin B is added to 14 oz. cow's milk, properly diluted (as at 1 month), the above increase in iron and copper results.

FOR the same reason that it is desirable to reinforce the milk supply of the infant with iron, the trend is toward the introduction of iron-rich solid foods at an early age. The iron content of many foods is variable, however. Leichsenring and Flor[4] found that children's diets planned to contain 5 and 8.5 mg. iron actually contained only 3.25 and 6.5 mg., respectively. Pablum, higher than most foods in iron and containing standardized amounts of this mineral can be administered as early as the third month, when nutritional anemia begins to appear (see chart above). Clinical studies by Summerfeldt[5] show that Mead's Cereal (of which Pablum is the pre-cooked form) is capable of increasing the hemoglobin percentage of growing children.

	IRON	COPPER
Cow's Milk, 20 oz.	1.44 mg.	0.24 mg.
Dextri-Maltose with Vitamin B, 1½ oz.	3.60	0.855
Mead's Cereal or Pablum (dry), ¼ oz.	1.70	0.09
	6.74	1.185
Daily Requirement*	4.18	"traces"

When ¼ oz. of Pablum is fed to the 3-months-old infant receiving 20 oz. cow's milk and 1½ oz. Dextri-Maltose with Vitamin B, a significant increase in iron and copper takes place.

* The desirable iron intake for children according to Rose *et al.* is 0.76 mg. per 100 calories. Infant of 1 month (8¼ lb.) and infant of 3 months (11¼ lb.), both require 50 calories per lb.[6]

[1-6] *Bibliography on request.*

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DR. CUSHING ACCEPTS PROFESSORSHIP AT YALE

(Journal A. M. A.)

Dr. Harvey Cushing, Boston, has been appointed Sterling professor of neurology at Yale University School of Medicine, New Haven, where he will devote himself to literary activities and research to the exclusion of clinical work. Dr. Cushing's laboratories will be in the Sterling Hall of Medicine, in association with the experimental laboratories of preclinical departments of the medical school. He will be the first incumbent of this professorship, which was only recently established, under a $300,000 bequest of the late John W. Sterling. It is expected that he will take up his new work this Autumn. Dr. Cushing retired from Harvard University Medical School September 1, 1932, as Moseley professor of surgery, a position he had held since 1912. At this time he also resigned as Surgeon-in-Chief of Peter Bent Brigham Hospital. Dr. Cushing was Associate Professor of Surgery at Johns Hopkins University School of Medicine, Baltimore, from 1902 to 1912, when he became affiliated with Harvard. Many honorary degrees from medical institutions have been conferred on Dr. Cushing. In 1922 he was awarded the Charles C. Mickle Fellowship of $1000 by the University of Toronto Faculty of Medicine. This prize is given to the member of the profession anywhere in the world considered by the faculty to have done most during the preceding 10 years to advance sound knowledge of a practical kind in medical art or science. In 1923 he was awarded the Distinguished Service Medal. During the World War he was a Colonel in the Medical Corps and Director of U. S. Base Hospital No. 5 (Harvard base hospital unit). He received the Lister Medal of the Royal College of Surgeons in 1930. He was President of the American College of Surgeons and the American Neurological Association in 1923, and of the American Surgical Association in 1927. He was the recipient of the Cameron Prize of the University of Edinburgh in 1924. Dr. Cushing's 'The Life of Sir William Osler", in 1925, won the Pulitzer Prize for biography.

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All the mother has to do to prepare Pablum is to measure the prescribed amount directly into the baby's cereal bowl and add previously boiled milk, water, or milk-and-water, stirring with a fork. It may be served hot or cold and for older children and adults cream, salt and sugar may be added as desired.

Mothers will coöperate with physicians better in the feeding of their babies because Pablum is so easy to prepare. It gives them the extra hour's rest in the morning and saves bending their backs over a hot kitchen stove in summer. Please send for samples to Mead Johnson & Company, Evansville, Indiana.

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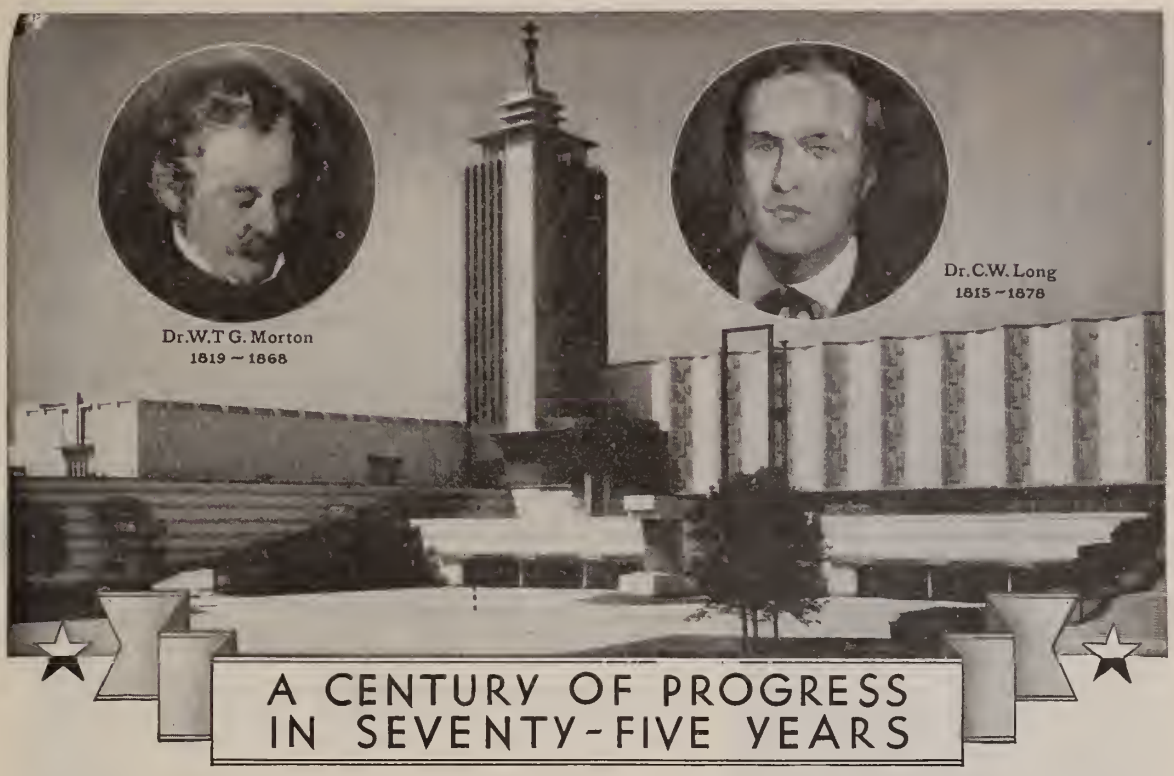
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Journal of The Medical Society of New Jersey

Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Vol. XXX., No. 9 ORANGE, N. J., SEPTEMBER, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

RELATION BETWEEN THE GENERAL PRACTITIONER AND THE PUBLIC HEALTH OFFICIAL*

HUGH S. CUMMING, M.D.,

Surgeon General, Public Health Service, Treasury Department,

Washington, D. C.

It is a pleasure for one whom fate has thrown into administrative duties as chief of the Federal Public Health Service to meet such a distinguished society of fellow-physicians, whose lives are devoted largely to the relief of suffering and to saving the lives of individuals whose gratitude they may see face to face. It is that loss of personal contact with the problems of patients which those of us engaged in such duties as mine feel is our greatest loss. On the other hand, it is possible that we may be in a position to observe and evaluate events and trends in the march of time more than the busy practitioner, whose time and energy are fully occupied at the bedside, operating table or laboratory bench. It is probably for this reason you have asked me here tonight to discuss the recently much mooted question as to the relationship between the general practitioner and the public health official.

Now, in the first place, it is needless for me to say that any views I may present are only my personal impressions, which may be of value because of the opportunities which have been afforded me by my official position during the past 13 years as Chief of the Federal Public Health Service, and a service of 38 or 39 years in various parts of the world, to hear the opinions not only of public health officials but of medical men in private practice and of the public in whose welfare we are equally concerned.

As a matter of fact, as has been recently shown by the controversy over the Report of the Committee on the Costs of Medical Care, there is no unanimity of opinion in or out of the profession, and indeed there must be so many varying factors, both personal and environmental, throughout the country, which affect opinion, that there never will be any written constitution of limitations in respect of the rights and responsibilities of these 2 sections of our profession which would be applicable to the whole country. I do not think there can be any stock prescription suitable for all regions or conditions. Rather must the relationship be suited to local environments. Nor indeed do I think it wise for us to believe that the remedy suitable for conditions of today need necessarily be applicable to the future. I am fond of quoting the couplet from Lowell—"New occasions bring new duties, time makes ancient ways uncouth",—and while I am afraid that, up until a short time ago, we were beginning to think ourselves as being like gods, having eaten the fruit of the Tree of Knowledge and to think that we had the wisdom of the prophets, I am inclined to think that most of us have been chastened enough during the past few months to realize that we are not prophets enough to be sure that the remedy

*(Address to Essex County Medical Society, Newark, N. J., February 9, 1933.)

for today will successfully fulfill the conditions of the morrow.

Still, we may be guided somewhat by the lamps of experience and judgments, to some general fundamental principles. To do this, we must discuss briefly the history of medicine in its broadest sense, the medical profession and its relationship to government, and this, of course, includes *State Medicine,* that phrase now used by sincere students of events as well as by medical demagogues, a war cry which either may lead our profession to its hurt if we follow unprincipled or short-sighted leaders, or may lead to the advantage of both profession and public if it awakes us to the importance of a careful study, by bodies such as this, of the present state of affairs, economic, social and scientific.

It seems unnecessary to do more than simply recall to such an audience as this the fact that the recognition of the duties and obligation of government in matters of public health is by no means a modern conception. We have instances of this recorded in all civilizations, from the imposition of certain restrictions upon the practice of medicine and fees by the Babylonian government, through the Egyptian and several Greek governments. This is shown by many laws, too, in Roman and medieval governments. There is evidence that the State appointed public doctors at least as early as Democedes (c. 510 B.C.), and the custom was extensively followed throughout the Roman Empire. In England, the first obvious intervention by the State was in the sixteenth century, on account of the existence of certain foci of disease among the poorest and most vagrant class of the community neither able nor willing to obtain medical advice and yet contributing to the spread of disease in the community. It became apparent that the State was the only available authority which could direct the application of advancing medical knowledge and practice to the problem. In the first half of the nineteenth century, such action of the State became more formal and statutory, both in providing medical and surgical treatment for the poorest classes and in formulating sanitary measures to protect the whole community against insanitary environment or the spread of infectious disease. We are all more or less familiar with the qualifications imposed by Emperor Frederick upon the practice of medicine, and the decree of the King of Naples as far back as 1782 providing care for tuberculosis, while we know of provision for sewage disposal and water supplies which still remains in the older Roman towns. I am inclined to think that the limitation upon the entrance of government in public health and medical matters in those days was the result rather of ignorance both of causation and treatment of disease than any other reason.

It is difficult for us to remember that, while the growth of modern industrialism and consequent growth of large urban centers led in Great Britain, in the middle of the nineteenth century, to nonofficial and later to governmental activities in the study of housing, water supplies, etc., for the industrial populations, it was not until within the memory of many of us here today that knowledge of the etiology and mode of transmission of infectious and communicable diseases was discovered. During the last decade or two, however, of the nineteenth century, there was perhaps more increase in knowledge of all the sciences, and in their application to medicine, than had occurred in any century of previous history. With the increase of this knowledge, medicine began to lose its mystery, the knowledge of which was confined to the medical profession, and became more or less diffused among the people at large, from whom, as well as from more advanced members of our own profession, there came a demand for the application of remedies for relief of such diseases as typhoid fever. During the following decade, there came a further knowledge of the insect-transmission of such other diseases as malaria and yellow fever.

Now, I cannot conceive that any individual is so blind as to believe it possible to fight such diseases through individual effort. It must necessarily come through that organized group action which we know as government. There has, therefore, within the past 30 or 40 years been gradually developing an organized effort for the remedy of such conditions,

for the control of food products such as milk, etc. At the same time we have had, through the application of discoveries in biology, chemistry and physics, a greater knowledge of the treatment of disease during the past 2 or 3 decades than in all the ages which have preceded it. In applying this knowledge in the prevention and cure of illness, the conditions which have surrounded the medical profession have radically changed. So vast has the store of medical knowledge grown that it has become impossible for any individual to acquire it all. Even if some transcended genius could accumulate the knowledge, it would be impossible for him to apply it alone. We have reached, therefore, a condition somewhat similar to that stage in military progress when the invention of explosives and of weapons of offense and defense made impossible the calling of the plowman from the field and the knight from the castle as an adequate defense for a country, and there evolved in this and other countries the system of a regular trained army with a somewhat less trained citizenry as reserve. So in the medical profession, speaking broadly, it has become necessary for the people, through their government, to organize a permanent, regular army of trained medical men, with their allied professions such as sanitary engineering, while to the great body of the medical profession are entrusted the duties of a reserve.

So long as the duties of this regular army of public health workers were confined to regulation of matters of sanitation, such as the control of water supplies, milk supplies, such engineering projects as eradication of diseases like malaria and yellow fever, or such police measures as enforcement of quarantine against pestilential and communicable diseases, there arose no conflict between such governmental action and the so-called private practitioners of medicine. Within the past few decades, however, conditions have developed which have brought our present problem. Do you realize that when many of us who are still engaged in active life graduated, there were practically only 3 specific remedies known for the prevention or cure of diseases—vaccination for smallpox, mercury for syphilis, and quinine for malaria? And I may add that in these later days of superior knowledge there seems to be a tendency to discredit the efficacy of even those! In the last decade or two, however, we have rapidly accumulated the use of the toxins and antitoxins, vaccines and serums. There have been remarkable and life-saving discoveries in the application of such biologicals as insulin and the use of glandular extracts. Application of this knowledge involves personal contact between physician and individual patient. During this period, too—and this is a matter which I think is of the utmost importance and is not yet fully appreciated by many members of our profession—there has been a rapid diffusion of knowledge of medical matters throughout the public at large. Perhaps I am old-fashioned, but I cannot help feeling that there has risen a school of so-called economists and socially-minded persons, who have been preaching the rights and privileges of this or that group of the people to the neglect, perhaps, of their responsibilities. Therefore, while unfortunately there are many unsolved medical problems of great moment involving the health and life of the race, such, for instance, as influenza, there is available for use by our profession and its allies and technical assistants a wealth of knowledge and resources which, if used for the benefit of all the people, would markedly carry forward that record in alleviation of suffering, prolongation of life, and increase of efficiency, which is the glory of our profession and admiration of our fellow-man. *The public is generally aware of this and expects its benefits.* It is asking, in the words of Jeremiah, "Is there no physician there? Why then is not the daughter of my people recovered?"

"Salus populi suprema lex" is as true now as when written. The provision of facilities for protecting the health of the people is one of the most important duties of government and necessary for the safety of the country. The problem is how and through what agencies shall it be given. Shall we, following some continental countries, administer to the poorer classes through officially appointed

medical men or agencies, or, following the lead of Great Britain, adopt a middle course; or, shall we attempt to continue our present system of at least theoretically providing medical assistance to the confessed paupers, leaving others to individual arrangements and the charitable administrations of private practitioners; or, shall we devise a better way, more in harmony with the genius and spirit of our people? We may dismiss the German way as repugnant to our ideals. There is much of good in the British panel system, but also much of active and potential evil.

So long as the whole armamentarium, both diagnostic and therapeutic, of the general physician and surgeon could be carried in the saddle-bag, and existing medical knowledge in his head; so long as his ministration consisted only in delivery of the baby, or a surgical operation, or diagnosis and treatment of the patient in his own home; our old system might be suffered. But these conditions no longer exist.

The knowledge of our interdependence has been co-existent since the time of St. Paul's wonderful words, "No man liveth to himself, and no man dieth to himself. The eye cannot say unto the hand, I have no need of thee." But with the application of recent discoveries in physics and chemistry to medical equipment, few, if any, individual medical men have the time, knowledge, or financial resources, to devote to charity; though to the honor and glory of our profession it may be truthfully said that, while perhaps no group has suffered more during this depression, none has given more freely of its time, energy and money. There are still "doctors of the old school" in every community of our country, but I do not believe it is right for either the profession or the people whom they serve to cast upon them the whole burden. I do not believe it is proper to depend upon the vagaries and caprice of private wealth to provide research facilities without which, as Pasteur said, a physician is a soldier without arms, or for the dissemination of medical knowledge, or for hospital facilities in which to apply it. Though this does not mean we shall not appreciate and use them when given, it does mean that it is the duty of government to see that facilities, and qualified persons to use them, are available. And when I speak of government I distinctly do not mean the federal government, whose constitutional limitations should be observed, but local and State governments, except in such matters as affect the people as a whole, such as quarantine, or research into matters of general interest.

The medical profession should not, and with its traditions of self-sacrifice it cannot, sit Canute-like, futilely trying to stop the tide of changing events with the meaningless cry of "State Medicine". State Medicine in some form has existed throughout the ages in every civilized community. Rather, as the best qualified group, we should carefully study and use our influence in obtaining public sentiment and legislation best suited for the time and place, not as a Trade Guild or Union, intent only upon self-aggrandizement, but in the interest of all.

The time will come, probably soon, when we shall have progressed as far as we may go in the prevention of diseases which will yield to environmental sanitation and to control by immunization. The next important development in public health and preventive medicine must be the reduction of illness and mortality from that large and important group of human afflictions which includes heart disease, cancer, the pneumonias, diseases of pregnancy and child-birth, and certain causes of infant mortality. This means that every individual must have adequate medical service, and that the public must be taught the importance of seeking medical advice at the time when it can be of greatest value—before illness has progressed to the point where little or nothing can be done about it.

I do not believe the Health Department itself should enter the field of curative medicine, except when it may be necessary under certain specific conditions to maintain clinics for the treatment of indigent persons for communicable diseases, where the only means of preventing the spread of infection is removing the source by treatment of the patient. It may also be desirable, especially in urban communities, that the Health Department

maintain certain diagnostic clinics as a means of case-finding and interesting and educating the public. Where such clinics are maintained, however, it goes without saying that their activities should not extend into the field of treatment. But the chief function of the Health Department will be the conducting of the intensive and continuous campaign necessary to popularize medical advice, and to bring the individual who needs medical attention under the early care of the doctor. It will also be the responsibility of the Health Department to develop in the public mind an appreciation of the value of the periodic physical examination, even though such examinations from year to year may show no condition calling for medical attention. Then the physician must do his part. He must cooperate with the Health Department by helping to devise some satisfactory plan whereby every individual may receive adequate medical care.

The strained relationship which now exists between the physician and the Health Department in many localities seems all the more deplorable because of the very evident fact that most of the dissatisfaction which has arisen can be attributed to misunderstanding. Some of the responsibility for this lack of understanding can be laid at the door of the health officer himself, as a result of his failure to take the local medical profession into his confidence, and to request its advice and assistance in the planning and execution of his work.

On the other hand, I believe that the fear of *State Medicine* has blinded many physicians to the fact that the Health Department may be helpful to them. Already, educational campaigns in the interest of general immunization against typhoid fever, diphtheria, and smallpox, have sent thousands of children to the private physician for vaccination, Schick tests and the like. School medical inspections, diagnostic clinics, and the activities of the public health nurses, likewise have resulted in referring untold numbers of defective children, mothers and infants to the family doctor for treatment.

Any trend which may be developing in this country toward *State Medicine* is the result of an underlying cause far more important than the activities of the health agency. The present economic situation with which the doctor is contronted is affecting the public as well. People are beginning to wonder if the burden for medical care for certain groups, which falls ultimately on the community as a whole, cannot be made lighter by preventing the need for such care. The individual who is not an indigent, but who cannot pay the usual price of adequate service, finds himself forced to go without, or to seek some plan whereby the expense of medical attention may be lessened.

In all seriousness, therefore, I venture to predict that, should there develop in this country a conflict over the question of whether or not medical service shall be supplied by the State or the community, the controversy will be waged not between the Health Department and the physician but between the public and the medical profession. It is my firm conviction that the public health agency can, and will, be the strongest ally of the medical profession in resisting the approach of *undesirable State Medicine; if* you will permit the health officer to join you in an effort to solve the problems you are now facing, or with which you undoubtedly will be confronted in the future. Why should not the public health agency and the practicing physician, before the situation becomes more difficult, join hands in working out a solution of the problem which will meet public health needs, give the doctor an opporunity to adjust himself to preventive medicine in private practice, and provide a plan under which each individual may receive adequate medical service, medical advice, and care, at a cost commensurate with his ability to pay, with just compensation to the physician for his services?

There are probably none among you here tonight who are not only conscious of, but who have been personally and directly affected by, the serious condition of the country. In such times of emergency and stress, we are fully justified in adopting, for the time being, methods of procedure which are not in consonance with the wisest course of procedure

in ordinary times. We should be careful, I think, in planning at this time, not to put into permanent form many things which are both desirable and indeed necessary at this time. In other words, we should be planning not only emergency measures for the day and hour, but carefully studying the more permanent changes in conditions, and endeavoring to have plans arranged to meet them.

INFECTED TEETH IN RELATION TO MORTALITY RATE OF MAJOR OPERATIONS*

Henry A. Cotton, M.D.,
Medical Director Emeritus, and Director of Research, New Jersey State Hospital,
Trenton, N. J.

Those who have observed patients suffering from mental diseases have known for many years that most of them were also victims of chronic constipation. Dr. Gjessing, now superintendent of the Dikemark State Hospital at Oslo, Norway, has told me that a former Superintendent of that institution 30 years ago treated all newly admitted patients by means of high enemas for a week or so after admission.

After determining in 1918 to hunt for chronic infection in our patients, I became convinced that many of them had serious gastro-intestinal stasis, and possibly intestinal toxemia. However, few investigations in this field were available. Fortunately, we found one man, Dr. John W. Draper, of New York, who had made some extensive investigations in this field. He taught us not only the method used to diagnose by means of x-rays, but also the method used by him to correct this condition. So, from 1918 to 1925, through the courtesy of Dr. Draper, some 300 patients suffering from so-called *functional disorders,* mainly dementia praecox, were operated upon, and their colons either wholly or partially removed. Out of this number, 75 recovered both mentally and physically following operation. In some cases it was necessary to perform 2 operations, ½ the colon being removed the first time and the other half on second operation. When the first operation had been a failure so far as mental recovery was concerned, the second operation was often followed by recovery. These patients were all suffering from chronic mental disorders, and in all probability would never have recovered their mental condition or left the hospital if the surgical methods had not been employed.

In this pioneer work the mortality rate was about 33.3%, which means that 1/3 of such patients died, usually of peritonitis. There seemed to be no definite explanation for this mortality. The technic used was the same in all cases. Yet, frequently, when such an operation was performed and no contamination was evident, and we considered the operation perfect, the patient developed peritonitis and died. Naturally we were criticized for this high mortality rate, although, as stated heretofore, the patients would never have been well mentally, and we felt that under the conditions the risk was justified.

In 1925 I was fortunate enough to spend several months in London with Sir Arbuthnut Lane, who was one of the first men to call attention to the importance of the colon with relation to intestinal stasis and toxemia. He had done many resections, and had developed a new technic, which consisted in releasing congenital bands of adhesions that were causing constriction in various areas. As the mortality from this operation was less than from resection, he preferred it. The gastro-intestinal x-ray studies of these patients showed definitely where these bands were located and the resulting constrictions caused by them.

In the Fall of that year we adopted his method of releasing adhesions found around the appendix, terminal ileum, ascending colon, hepatic flexure, splenic flexure, and descending colon. This operation was attended with more success than the operation for resection, or total removal of the colon, because the

*(This article was written and submitted by Dr. Cotton only a short time before his death. As it constitutes a final summary of the work he had been doing for so many years and in the face of serious opposition and criticism, and because it is, literally, his "last word" on the subject, we are pleased to publish it even though it be posthumous. —Ed.)

mortality was reduced from 33.3% to about 19%, and the recovery rate was 37%.

From 1923 to 1930 we performed 493 operations for the release of adhesions. Of that number, 148 patients permanently recovered. In 1924 and 1925 we performed 291 operations, and 109 recoveries resulted therefrom. The mortality rate of 19% we considered still too high, but we could not determine why there should be a higher mortality rate in these patients, because the colon was not opened and there were no visible sources of contamination or infection.

We did not understand at first why it was that some of the patients made a speedy recovery from their operations; others recovered for a while but mental symptoms returned; and in still others there was a failure to recover mentally. We have since learned that, although the condition of the colon at the time of operation was apparently good, it was frequently so badly diseased that the adhesions re-formed and the intestinal toxemia went on as before. This fact was discovered in 1929, when we operated the second time on a number of patients. In some of the second operations, the colon had to be removed; and in others, releasing the adhesions resulted in recovery without any further recurrence.

In reviewing my private case histories from 1928 to 1932—virtually the same as those at the State Hospital—we find the following situation: Operations totaling 148 were performed for release of adhesions. Only 7 patients died; a mortality rate of 4.8%. In 1928 and 1929, 4 deaths occurred; and from 1930 to 1932, only 3. The recoveries in this group were 56, or 38%. Eighteen resections were done, with only 4 deaths, or 22% mortality. Two of these deaths occurred in 1930, before we had changed our technic; both patients were chronic cases of long duration, one being an epileptic; both died from peritonitis. The other 2 patients died of chronic myocarditis, one 24 hours and the other several days after operation, but that was not due to peritonitis. So that the deaths from resection due to peritonitis were only 11%, contrasted with the rate of 33.3% at the State Hospital for cases from the earlier period of 1918-1923.

Now that we have eliminated the mortality rate from operations on the colon, either for release of adhesions or resection, which was the principal objection raised against them, we see no reason why this procedure should not be adopted as a routine measure in the treatment of mental patients where it is indicated.

We learned a very important fact from 2 patients operated upon the same day, July 2, 1929. B. S., 30 years of age; duration 2 years; paranoid conditions with marked evidences of a chronic infection. Tonsils had been previously removed. Teeth were badly infected; patient took my advice and had them all extracted. Gastro-intestinal x-ray studies showed that she had a serious stasis due to adhesions, whether congenital or acquired could not be determined. The important point was that she made an uneventful surgical convalescence, and was discharged from the hospital 3 weeks following operation.

The other patient was E. L., 53 years of age; duration 3 years. In this case only the molars and bicuspids in the upper and lower jaws were extracted, leaving about 8 upper and 8 lower front teeth *which did not seem to be infected*. This patient developed peritonitis and died within a week.

Here we have a condition which was almost experimental in character, although not planned as such: 2 patients having the same operation on the same day, similar pathologic conditions and similar technic, with practically the same sterilization. The one with all teeth extracted made an uneventful convalescence and the other developed peritonitis and died. The only difference noted was the fact that all teeth had been removed in one, while, in the other, only the suspected infected teeth had been extracted; but, *those remaining were later found to be badly infected, although that fact was not apparent in the radiograms.* We can assume with reason, therefore, that the outcome of the 2 cases was certainly influenced by the presence of infected teeth in one and absence of them in the other. These 2 cases taught us, then, the importance of the rôle of infected teeth in causing our high mortality from 1918 to 1923.

I soon made it a rule not to operate for

either resection or release of adhesions in patients until all teeth were extracted, irrespective of the age, for the following reasons: (1) Mental recovery often was retarded or hindered by the remaining infected teeth; (2) in many cases the death of the patient from peritonitis could be blamed on the infected teeth.

As an illustration of the first condition, I would cite the following case: B. H., a young girl of 20, who had been sick for some months. When admitted to the hospital, she was somewhat exhilarated, talkative, and inclined to be violent. Tonsils were enucleated, and infected molars and bicuspids removed, leaving about 8 upper and 8 lower front teeth. Even before these teeth were extracted, patient went into a catatonic stupor, was mute, refused food, was inactive, sat all day with head bowed; mouth was full of saliva and, when opened, the saliva drooled out. She was somewhat resistive. X-ray studies showed that she had a gastro-intestinal stasis, and the history stated that she had had constipation since childhood. She was operated for release of adhesions. A very unique condition was found, in which the cecum and ascending colon were bent upon themselves, the cecum being up next to the liver and gallbladder, and acute angulation of the ascending colon due to these adhesions. This condition was corrected. The patient fortunately did not succumb to the operation, but little mental improvement followed. For several days she talked, but soon lapsed again into mutism, although she did eat. Finally, 2 lower bicuspids were extracted. A week later she began to clear up, started to talk, showed marked mental improvement and never again showed any psychotic symptoms.

After she recovered, I suggested that her remaining teeth might be infected, and might cause a return of her trouble. They were extracted, and cultures made from them showed all to be infected. This case impressed me very much, and seemed to demonstrate without question of doubt that we were making serious mistakes by leaving in teeth which were supposed to be normal, but in reality were infected, even though the x-rays did not indicate it.

It was evident, then, that many cases in which our work was apparently unsuccessful were due to this fact. We could cite many more cases, but they would only be repetitions. There was sufficient evidence to convince me that our failure to extract all teeth was a reason not only for our high death rate, but also for failure of the patient to recover mentally.

That we were correct in this opinion is shown by our subsequent work. Of 113 operations performed for releasing adhesions in the colon, only 3 patients have died, a death rate of 3.7%. In these 3 cases, infected teeth were present. The fact that we reduced the death rate to that point justifies us in considering that infected teeth play an important rôle in the mortality. It is true that I have operated on several patients where only the badly infected teeth were extracted and those remaining were apparently good, and the patients recovered surgically and mentally.

Altogether we have 75 cases in which recovery of the mental condition followed resection, and 149 cases in which recovery followed release of adhesions. Besides this group, which were patients at the State Hospital at Trenton, I have operated on 149 patients for release of adhesions at the Charles Private Hospital, with 50 recoveries and a great number improved. We can add to this 3 patients who recovered following a secondary operation for resection. Thus, we have a total of 277 patients who have recovered their mental condition permanently as a result of operation on the colon. There are undoubtedly many patients in the State Hospital who were operated on for release of adhesions without success, who would have recovered if a second operation had been performed.

Since January 1932, I have operated on 26 patients for release of adhesions, mostly dementia precox types, and out of that number, 14 have recovered, which is over 50%, and only 2 died. It is interesting to give the reasons for these deaths.

One was a Hungarian man, diagnosed dementia praecox, paranoid type. He had all teeth extracted and improved somewhat. Because the family could not afford to keep him in the hospital any longer than necessary, they in-

sisted that he have his colon operation as soon as possible. As a rule, I find it necessary to wait at least a month following extractions before any operative work is undertaken. In this case, as the man seemed to be doing so well, I only waited 10 days. He developed a paralytic ileus, and died within a week.

The other case was a boy of 19, dementia praecox of 3 years' duration. In spite of my insisting on extraction of all teeth, the family refused, and 9 upper and lower front teeth remained. He developed a serious heart condition immediately following operation, and died within a week.

While a little more serious than an ordinary uncomplicated case of appendicitis, still there should be no more reason for operative fatality from release of adhesions than from the operation for uncomplicated appendicitis.

I think one is justified, from the facts deduced above, in stating that there is direct connection between infected teeth and mortality rate. Consequently, I make it a rule now, in the mental patients at least, not to operate either for release of adhesions of the colon or resection until all teeth have been extracted. (Of course infected tonsils are not considered, because they are enucleated in all of these patients.)

But the question arises, "How do these infected teeth affect the individual and cause the death?" From my observations I am convinced that there are several ways in which death could occur as a result of infected teeth:

(1) We know that the lymphatic system carries the infecting organisms from the teeth and tonsils all over the body, and that these various bands of adhesions are permeated by myriads of lymphatic vessels. Consequently, when it is necessary to make a large dissection to release these adhesions, there is the possibility that microscopic infection is liberated in the abdomen, which causes the peritonitis.

(2) It can also be assumed that the resistance of the patients is substantially lowered by the systemic toxemia as a result of chronic infection, and therefore they have no resistance to peritonitis and are unable to prevent its occurrence.

(3) It is undoubtedly true that the toxemia from infected teeth does act upon the heart muscle. Consequently, the shock of an operation, especially the effect of the anesthetic upon the heart, is sufficient to affect the heart muscle, already weakened by the myocarditis, and cause the death. This has happened to several of our patients in whom there were no evidences whatever of peritonitis.

From these experiences, mostly with my own private patients, who do not differ at all from the patients at the State Hospital, I am convinced that no patient should have a serious abdominal operation, or any operation, without all infected teeth being extracted. Of course, there are conditions where the surgeon has to operate at once, such as an acute appendicitis, and he cannot question infected teeth. However, there are many other operations in which the surgeon has a long time to observe the patients and to determine whether or not they have infected teeth.

From these facts, therefore, it would seem that the question of infected teeth should be seriously considered by the surgeon before any operation which can be postponed is undertaken. Of course, I do not mean to say that operations upon individuals with infected teeth are always fatal. I, myself, have operated on many patients in whom some teeth were remaining, and who have survived the operation. However, that does not nullify the point that in the fatal cases the infected teeth had a direct relation to death. From my personal knowledge of many patients who have been operated on in this vicinity in the last few years, I am convinced that some of them, at least, could have been saved if the surgeon had recognized this very important fact.

Conclusions

(1) A laparotomy for any purpose is dangerous and liable to result fatally if the patient has infected teeth.

(2) Recognition of this fact has reduced my mortality rate for operations for release of adhesions from 19% to 3%.

(3) Of the so-called functional group, 80% suffer from pathologic conditions in the

colon which must be surgically corrected before they will recover their mental condition.

(4) As the mortality has been materially reduced, I do not see how any criticism, from the standpoint of the public as to these surgical procedures, is justified.

SOME OF OUR PRESENT DAY PROBLEMS

Max Danzis, M.D.,
Chief of Staff, Newark Beth Israel Hospital,
Newark, N. J.

At no time in the history of medicine have its economic problems been so generally discussed by both the medical profession and the public, as they are today. A great deal of space has been devoted to this subject by the medical and lay-press, especially since publication of the Wilbur Committee's Report on the Costs of Medical Care. It became and still is a controversial subject from many angles, much misunderstood and frequently misquoted by some of its champions and many of its opponents. Beginning with pre-medical and medical education, which is constantly being made more exacting, more difficult and much more expensive, and continuing right through the early period of medical practice, the physician of today is facing problems which require a continuous process of re-adjustment and adaptation to rapidly changing social conditions.

It is safe to say, without being guilty of overstating, that in no other field of American education have so many drastic, constructive changes been made and so many healthy reforms instituted, as in medical education during the past 3 decades. Prior to 1904 entrance requirements for the study of medicine were, with very few exceptions, a 4-year high school course at most. Through the efforts of the Council on Medical Education and Hospitals of the American Medical Association, higher and better standards were established throughout the United States so that between 1904 and 1918 medical education was put on a university basis. This was followed by a 50% reduction in the number of medical schools and a proportionate reduction in the number of students. Higher standards in the teaching staffs, better organized clinical facilities and well equipped laboratories for teaching the basic medical sciences were established in most medical schools. But these high pre-medical and medical educational standards have been accompanied by a tremendous increase in its cost. During the past 25 years large sums have been invested in medical teaching plants throughout the country. A number of medical centers were constructed in some of the large cities and many drastic changes to conform with the modern teaching requirements had to be made in all schools, thus making the maintenance costs distributed through the per capita charge very high.

It is still a debatable question whether a full 4-year pre-medical, academic course should be a pre-requisite to the study of medicine, since many students go through the third or fourth year of their pre-medical course in a very perfunctory manner. They lack the enthusiasm so essential to real scholasticism, because they look upon these extra courses as only a stepping-stone to their medical education. Their objective is medicine. There may be many subjects in the college curriculum which do not sufficiently interest them or have no practical application to their contemplated medical study. It is, therefore, pertinent to ask whether a combined 6-year pre-medical and medical course, with special attention in the preparatory curriculum to subjects relating to the science of medicine, would not be more practical and, incidentally, less expensive.

In order to establish certain guiding principles for future progress in medical instruction, a "Commission on Medical Education" (the so-called Lowell Commission) was appointed by the Association of American Medical Colleges, and that Commission has made the following suggestions to the Federation of State Medical Boards and the Association of American Medical Colleges: "That a truce be established for a number of years during which any member of the Association might

experiment with medical education without penalty to its graduates." Such an arrangement gives the schools freedom of self-determination with respect to curriculum and educational requirements.

Raising the old hospital standards to a higher point of efficiency, as advocated by the American Medical Association and, particularly, by the American College of Surgeons, has kept pace with these requirements for a higher medical education. A careful analysis of the quality of medical service rendered 25 years ago with that of today, would show a marked improvement in the end-results of patients treated at any of our modern hospitals, which if computed in dollars and cents, would more than compensate for the increased cost of the present-day medical care which makes these results possible. I do not subscribe to the statement that the modern hospitals are luxurious hotels. It may be true of a few selected institutions, or of a very limited number of specially equipped rooms in any modern hospital, but the average accommodation for the middle-class patient is just about in keeping with the ordinary living conditions of our middle-class people.

These higher standards in education and service, which were primarily instituted for the benefit of the people, have, strange to say, reacted against the medical profession. A great cry has arisen, pointing out the "high cost of medical care for the American people". By implication, this charge is usually aimed at the medical profession but, upon careful analysis of the distribution of this high cost, we find that most of it goes for maintenance and equipment of our highly specialized medical institutions. It is definitely shown that only 45% of the total cost of medical care goes to physicians. It is also estimated that out of the total amount spent annually for medical services, a substantial portion is spent for chiropractors, naturopaths and faith-healers. About $360,000,000 is spent annually for patent medicines bought by the patient on faith, to cure a self-diagnosed disease. Every practicing physician is familiar with the tremendous decrease in morbidity and mortality which is directly attributable to modern medical methods, regardless of their increased cost, but instead of refuting this criticism, even in part, some physicians have joined the multitude, thereby tacitly implying that the fault may be attributed to the medical profession. Very few have thought of calling to the attention of the people that the increased cost of illness is simply keeping pace with other factors in the "high cost of living". It should have been repeatedly pointed out, that the patient belonging in the middle or lower economic brackets, is living in a modern apartment or private dwelling; goes to his business or place of employment in a privately owned motor car (may be bought on instalment plan); his home is fairly well and comfortably furnished; has a radio or player-piano; visits 1 or 2 moving picture houses weekly; but had never thought of—*sickness* and it caught him unprepared. He was prepared to pay his monthly rent, his instalment on the radio, motor car, musical instruments or house furniture, his life insurance or even his fire insurance, but he failed to provide insurance protection against the most important asset of his entire existence—*his health.*

A concerted effort should have been made long ago to call the attention of the people to these facts, warning them that illness is always an unwelcome and unexpected visitor, and that necessary preparations should be made to meet this emergency, either in the form of insurance or personal thrift.

Instead of that, the "high cost of medical care" became a pet subject for discussion before medical groups, but no measure to relieve that condition was offered by anyone. We decried the increased cost of hospitalization, the expense of many laboratory procedures, some of which we were told were unnecessary; we talked glibly about excessive specialization and machine medicine; we pleaded for the return of sound diagnostic clinical methods; in other words, we were conscious of the fact that in the attempt to adopt more perfected and effective methods of medical service, we had somewhat overstepped the mark.

While this self-criticism was going on in our midst, there were constant drives being

made by local, State, or national medical bodies for higher standardization in our hospital practices, which carried with them a proportionate increase of medical cost. It was not unusual to hear or read addresses by some of our prominent medical teachers, in which they deplored the present day tendency toward excessive and unnecessary laboratory procedures, and other hospitalization expenses; but no attempt was made to instruct their students in definite procedures which are essential to correct medical diagnosis and adequate service, nor was any plan formulated for the guidance of either the private practitioner or hospital groups for the elimination of non-essential and excessive laboratory procedures responsible for the increased cost of medical care. I am not aware of any attempt to enlighten the people on these points, but I do know that during the past decade the medical profession seems to have been on trial before the bar of public opinion.

The public or the consumer of medical service is interested in that subject only from a selfish point of view and that is: "How to obtain medical service for a price commensurate with the ability of the buyer to pay." How this can be brought about and what effect it would have on the *quality of service* and *morale* of the *profession,* does not concern them. On the other hand, the medical profession looks at it from an entirely different point of view. Contrary to the belief of some, in this instance it is not a case where the one who supplies the demand is attempting to get as much as he possibly can for services rendered, since it is a well-known fact that all through the ages these lofty ideals and high ethical concepts of self-sacrifice, willingness to serve freely and unstintingly, wherever and whenever mankind was in need of it, were the guiding principles of the medical profession.

The antagonism shown by the medical profession against this so-called socialization of medicine, is not founded on a commercial basis, as I shall show later. Some of the remedies offered would abolish the personal relationship between physician and patient; would lead to restriction of freedom of action; and would have a tendency to establish medical hierocracies.

The "Wilbur Commission", appointed to study the cost of medical care, pointed out that the problem of today is the provision of medical service to the people of the United States at a moderate cost. "That medical service, adequate either in quality or quantity, is not received by many. * * * That a tremendous amount of physical pain, mental anguish, needless deaths and social waste, is a result thereof. * * * That there is a standing barrier between the practitioner, able and eager to serve, and patients who need the service but are unwilling to pay for it."

This is rather a strong indictment and, in my estimation, grossly over-stated. I do not believe that there is such a tremendous amount of unrelieved physical pain and mental anguish which may be attributed, either to indifference or the refusal of the medical profession to serve. It is well-known that every hospital, large or small, throughout the country, but particularly in the thickly populated industrial areas, has an efficient, well equipped in-patient or out-patient department—free or part-pay service—and extends these facilities to all who apply. There are instances, particularly in the rural districts, where medical service of a high quality—whether it be pay, part-pay or free—cannot be obtained, but these are exceptions.

The keynote of the entire complaint against the present costs of medical care is that it is unevenly distributed. That the increased specialization with its large investments of capital in building and equipment, has not reduced the average per capita cost of medical care which is at present about $30.

Studying a group of 9000 white families for the purpose of establishing the costs of medical service, it was found that 4% of those families incurred collectively as much medical expense during the year as did the other 80% of them. This uneven distribution was found in the same degree in all other group studies, regardless of income or location. The Committee points out that there are deficiencies in medical service with respect to mental hygiene—that if proper facilities for the treat-

ment of these patients in the early stages were established, some would never reach the stage where hospital confinement becomes a necessity; that less than 7% of the population has an annual complete physical examination; that only 51% of city children, and 37% of rural children, have undergone a health examination prior to their sixth birthday; that immunization against diphtheria, in 1931, was limited to 21% of the urban and 18% of rural children.

It is hardly fair to put the blame of this lack of utilization of preventive medicine upon the medical profession, since it is a well-known fact that most laymen hesitate or refuse to seek medical care unless absolutely necessary. It is also well known that the medical profession, through local, State, or national bodies has constantly advocated preventive medicine to the public. One only has to recall the diphtheria immunization campaign carried on by our State Society, urging people to take advantage of this preventive measure, to realize that this small percentage of immunized children both in the urban and rural districts is not the result of any lack of medical service, but is due, rather, to indifference and lack of necessary appreciation of the value of preventive medicine, on the part of the public.

The Committee also points out that in rural areas medical practitioners may be unavailable, that many communities are undersupplied with both physicians, hospitals, and other medical facilities, while others have a surplus. For instance, there was 1 physician to 1431 in South Carolina, and 1 to 571 in California. There were 19 dentists to 100,000 population in Mississippi, and 101 in Oregon. That only 10% of persons with annual incomes of $1200 receive any kind of dental attention, and only 21% of individuals out of the entire population receive any dental care at all during the year. That the percentage of dental care does increase in proportion to the individual income, reaching its maximum of 60% in the income class of $10,000 or more. Attention is also called to a well-known fact that there is an unequal distribution of specialists; that there are too few in some and too many in other locations; and that the total percentage of specialists is rather high—30%. The correctness of this latter estimation may be questioned. Since the Committee probably gathered its statistics by a personal inquiry, many who classify themselves as specialists in certain branches of medicine, may not be truly classified. There are many men classified as general surgeons who are practicing general medicine privately and doing general surgery in hospitals. The same holds true of other specialties.

In discussing the professional income, the Committee points out: that this is less evenly distributed in medicine than in the other professions; that 1/3 of all private general practitioners had net incomes of less than $2500; that the average net income of the general practitioner was under $4000, while that of the specialist was $10,000; that 40% of a doctor's gross income goes for professional expenses, such as office rent, maintenance, and replacement, and between 10% and 20% is lost in collections; that the professional net incomes were reduced in 1931-1932, with the reduction varying between 19% in the New England and Pacific Coast States, to 50% in the West and South Central States.

There is an apologetic allusion that some medical conditions are needlessly prolonged and some unnecessary operations performed, in order to increase the income of the physician or surgeon. Admitting that there may be such instances, we may safely and honestly state that they are, fortunately, so rare that they have no influence on the cost of medical care.

They point out that the nation's non-profit basis hospitals conducted by religious, racial, industrial and fraternal organizations and governmental bodies, have an investment of more than $3,500,000,000.

That the total equipment for medical and dental service, including 7000 hospitals with a total capacity of 1,000,000 beds, is estimated to be close to $6,000,000,000, and that $3,500,000,000 of this investment is made by the public without expectation of any return. In other words, an attempt is made to show that an increasing proportion of the medical service which is rendered by practitioners "is given

through a capital investment which is provided by the public for the benefit of the public"; an erroneous assumption because most of the work done in these large institutions is contributed by the physicians gratis, and for the benefit of the public.

Based upon various statistical deductions and upon the experience of various organizations which provide service of good quality upon weekly or monthly fees, the Committee came to the conclusion that if all these highly specialized medical facilities were properly organized and coördinated, medical care, excluding all capital charges, could be obtained at a cost of $20 to $40 *per capita per annum*. It would include the services of physicians, dentists, hospitalization, laboratories, radiography, drugs, eye-glasses and such other items. The Committee admits that for low-income families, even this rate would be a hardship. For instance, a family of 5, with an income of $1500 would have to pay $100 to $200 a year for medical service.

The answer to this last statement would be an appeal to capital for less exploitation, and the payment of a more liberal living wage which, in many instances, borders at present on a semi-starvation basis.

It is stated that medical service is at present so complex "that it has outrun the development of its organization", and that a patient may receive treatment from different specialists which is not coördinated with the treatment administered by the family physician, particularly when he goes to a hospital for treatment, and after discharge from the hospital his record may not be available to the physician or the clinic which becomes responsible for his subsequent care. This again is an over-statement; I am tempted to say that it is a misstatement. It is well known that all hospital records are, with the permission of the patient, open to the family doctor or to another hospital. An abstract is always sent to the family physician when requested, containing the essentials of the diagnosis, clinical course, treatment, and prognosis.

In comparing the costs of education and the costs of medical care, the Committee calls attention to the fact that, whereas in the educational system a definite attempt is made to eliminate waste and maintain standards, by community budgeting or regulating expenditures through coöperation of the school personnel, such as school boards, superintendents and teachers, this is not done with regard to medical care. Now let us see whether this opinion of the Committee concerning costs of education is generally accepted. Probably, if a committee were appointed to study this question it might arrive at a different conclusion.

In a recent article published in the April number of Mercury by H. L. Mencken, which I am abstracting, we find a strong indictment of the high cost of public education at present. The annual cost of education in 1880 was close to $80,000,000, which was a *per capita* cost of $5 per annum. This was increased to $250,000,000 in 1903; $500,000,000 in 1913; and, in 1914, the *per capita* cost *per annum* was $21.34, or 4 times as much as in 1880. Then, as Mr. Mencken put it, "the pedagogues began to fall upon the taxpayer in real earnest, turning his pockets inside out". By 1920, they were taking $1,000,000,000 of his money; and it advanced to $2,000,000,000 in 1926. The number of pupils taught in the schools at present is about 30,000,000, which is only double that of 1880, but the amount of money asked was the colossal sum of $3,388,000,000; bringing the *per capita* cost for general education close to $100 instead of $5 as in 1880. "The public schools have gone on a joy ride", says Mencken, criticizing the modern tendency of putting backward children into special classes to stimulate whatever latent gifts they may possess, or assign them to a school of half-wits where they can remain for years under experts trying to "solve the insoluble and achieve the impossible, and where they are surrounded by a physical equipment more expensive than that of a high-class hospital or night-club".

He points out that the cost of educating the normal pupil is now, in all probability, not more than 3 to 5 times what it was in 1880, but the cost of struggling with the uneducatable, has begun to run into fantastic figures, and so the total bill is now 20 times what it was in 1880. "That the public schools are now

vast machines for grinding up the money. * * * They have taken the care and upbringing of children out of the hands of parents and thrown it upon a gang of irresponsible and unintelligent quacks." But, after all this severe and smart criticism, he offers no remedy; leaving that to God. Very gracious of him to do so.

How are we to remedy this unequal distribution of medical service? What system should be devised so that we may reduce its cost and place efficient medical service within the reach of all?

The Wilbur Committee in attempting to find a solution to this problem, states at the outset that it believes in a plan of evolution and that the development and growth of its plans should come from existing institutions and organizations. It offers no panacea. It does not propose any single plan that is adaptable, or any solution that is applicable to all regional variations in the economic resources of the country. It does not propose an immediate adoption of programs which involve sudden large increases in expenditures of private public funds. The Committee has gone into a detailed elaboration of various plans and has offered many constructive suggestions. It pointed out many deficiencies in our present system of medical care to which any fair-minded public spirited person—whether physician or layman—must subscribe. There are a great many practical suggestions and very distinct well-founded criticisms, such as waste in our hospital organization and scientific planning on the part of community groups, both lay and professional, with reference to the distribution and location of its medical service.

Some of the recommendations show many inconsistencies. For instance, the Committee asserts that "man is not a standardized machine and each individual reacts differently to the various conditions of life". The point is stressed that the family physician should be restored to his place of responsibility and trust by substituting coördinated for un-coördinated relations with specialists and other agencies. That every effort should be made to maintain this personal relationship between patient and his physician, which is an essential part of the best medical practice. Can the principles just enunciated be carried out under the recommendations and through the suggestions made by the Committee?

Recommendation 1. That medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. This group should be organized preferably around the hospital, suited into comprehensive community medical centers, which should include general practitioners as well as specialists on their Staffs. The medical and dental service should be organized as a group, accepting the responsibility for furnishing complete medical service for the local population.

Will the family physician be restored to his place of responsibility and trust through such a plan of group practice? In accepting the responsibility for furnishing medical service for the local population, what method will be adopted and to whom will the power and privilege be delegated to select the family physician for the patient? If man is not a standardized machine, each individual reacting differently to his environment, how will it be possible to fit the medical service of an entire community into a medical group organized and conducted upon definitely prescribed medical standards?

In its provision (*Recommendation 4*) for the planning and coördination on a local and regional basis of all health and medical services, it is recommended: that this should be an important function for every State and local community; that agencies should be established to evaluate and coördinate the existing preventive and curative medical service; to eliminate services not needed, and to stimulate services which are needed; that it should be the function of these agencies to arrange for a better geographic distribution of practitioners and a better control in the quality of the medical service, to assist and guide patients in the selection of competent practitioners, and to restrict specialization to those only who will furnish evidence that they possess

special training and ability in that particular field.

How are these local agencies to be established? Should their membership consist of professional and lay groups appointed by County, State, or National medical societies and other civic bodies, or should the State exercise direct supervision over them? The Committee has no definite answer to this question.

There is a serious objection to State supervision, since it would create a distinct medical bureaucracy, whose appointment and guiding principles would largely be influenced by their political affiliation. It is impractical to relegate to a committee the restriction and the distribution of specialties, particularly with reference to their training. The reputation and prestige of a specialist are established in 2 ways: (1) through his fellow practitioners in the community, or those associated with him in his hospital activities, who are in the best position to judge his qualifications; and (2) by the selective type and quality of service that he renders to the public. I do not believe that any appointed group of physicians should be given the sole right to determine when a man has reached that stage of proficiency in a particular branch of medicine to entitle him to be known as a specialist in that field. For the same reason, it is equally impractical to assign to any committee or group the right to select, for the patient, competent practitioners. Will that selection be always based on pure merit? What will be the standard that the Committee will adopt and will the patient be satisfied with the selection made for him? What will be the reaction of those not included in the most competent group toward this selective group as to their competence to judge other physicians' qualifications? Will not such a system give rise to competition between different groups, resulting in the same evil that we find today in industrial and compensation insurance?

It is stated that the patient may receive a better quality of care from a well-rounded group than he would from individual physicians practicing independently. Now, this may be true of certain selective groups whose medical ideals are much above the average, as is exemplified by a few well-organized private clinics today. Generally speaking, it is a fact that in the average group there is a tendency to destroy the personal relations between patient and physician, and it is also safe to assume that the salaried physician does not have the same professional independence that he has in private practice.

Recommendation 2. The Committee recommends a better development of all basic public health service whether provided by governmental or non-governmental agencies, so that it may be extended and made available to the entire population according to its needs. These agencies should be under the direction of especially well trained officers employed by local or State governments, whose tenure of office should be independent of political consideration. That the *per capita* allowance for local health work should be increased from its present $1 rate to $2-$3.

It further recommends that the costs of medical care should be placed on a group-payment basis, through the use of insurance, or that of taxation, or both of these methods. That cash benefits, that is, compensation for wage loss due to illness, should be separate and distinct from medical service. At the same time, the Committee tries to make clear that there is no intent under that system to preclude the continuation of medical service on an individual-fee basis for those who prefer the present method.

With reference to a practical utilization of this principle, voluntary coöperative health insurance, or compulsory health insurance by legislation for low-income-groups which is to include all forms of sickness, therapeutic as well as preventive care, is recommended. Voluntary hospital insurance for individuals or groups, such as is being attempted by the Hospital Council in Newark, is also recommended.

The Committee points out that in most European countries every employed person earning less than a specified income is legally compelled to insure himself against illness; as in Germany, where 2/3 of the population today is covered by insurance. That *compulsory health insurance* including medical and

cash benefits for persons whose income does not exceed 1800 francs was adopted in France in 1930; and Denmark and Sweden depend on *voluntary insurance*. It is also pointed out that the British Medical Association, opposed to the insurance scheme in 1912, has now officially recognized it and advocates extending that service so as to include all dependents and all classes of wage earners irrespective of whether they are working, middle, or high class employees. The mistakes in the original plan of insurance adopted in England, in 1911, were that the worker could not change his doctor for 1 year, and that only young and inexperienced men were willing to accept that service. That there was considerable opposition from the conservative press, and difficulty in adjusting time for service and the obtaining of medical attention during the night, and that the Medical Association did not coöperate. Some of these obstacles were entirely eliminated and others were adjusted to the present demands and the plan is now successfully operating, according to the report of the Committee.

It may carry us far afield to enter into a discussion of the merits or demerits of the insurance system. Nevertheless, I feel impelled to contrast briefly the service rendered in New Jersey by insurance groups with that rendered by the hospitals to the indigent poor. In the former instance, the service is bought by the carrier with the distinct understanding that adequate, high quality, medical service be rendered to the injured workman at all times; while in the latter instance, the service is purely based on a humane altruistic principle.

Do the insurance companies provide the highest type of medical service to the insured? Does the injured person have the free choice of his physician or surgeon? It is well known that the physicians employed in compensation service, with the exception of a few experts, are not men who have undergone a prolonged period of surgical or medical training under the supervision and guidance of the directing head of that service. As a matter of fact, most men doing compensation work have, to my knowledge, had very little training except probably an internship of 1-2 years following graduation from their medical schools. Most of them are so busy with their Court work and their private practice that they have very little time left for any hospital or post-graduate study. Gradually, they lose interest in the true art and science of medicine, concentrating their attention upon that branch of contract practice which is thoroughly permeated by a commercial spirit, which gradually destroys all other incentives that may be left in the individual doctor for the better things in medicine. He becomes a tool in the hands of his employer.

Now let us see what kind of service the hospital renders to its indigent sick—a service which is purely voluntary and altruistic, and free from any commercial taint?

As soon as a patient enters the ward service he is placed in charge of a physician or surgeon who has gone through a long period of special training in a particular branch of medicine or surgery. True, in this case also, the patient has no right to choose his physician, but the Medical Staff, constituting itself as the guardians of the health of these patients entrusted to their care, see to it that only the best and most efficient members in certain branches of medicine are chosen from their midst to render the best possible service that can be obtained in that community or that group. Everything is done to safeguard the interest of that patient. No effort is spared to give him the finest and best possible service so that his health may be restored or, if he is seriously injured, that he may be quickly cured and so rehabilitated that he may become a useful member of society. Herein lies the difference between medicine founded on an altruistic principle, free from commercial taint, and medicine which is largely governed by pecuniary interest and in which the patient is only a pawn in the game.

Many other suggestions modifying the original 5 *recommendations* describing the various methods to be applied in the development of a satisfactory medical program, appeared to be the result of a wish and they seem to be, at least for the present, more theoretic than practical. They are based on the assumption

that some of these plans can be carried out successfully, but there is no definite machinery provided for its consummation. To quote the *Minority Report*: "We believe it to be far beyond the possibility of its ultimate value. It is admittedly an idealistic plan, based almost solely upon theory. There is nothing in our experience to show that it is workable or that it would not contain evils of its own which would be worse than those it is supposed to alleviate."

Among other recommendations which are most favorable from a medical standpoint, are the following:

(1) That better attention should be paid to the teaching of the social aspect of medical practice.

(2) Better opportunities to be extended to post-graduate work.

(3) Broader educational background for dentists.

(4) System of nursing should be remoulded (nurses' aides, nursing midwives).

(5) A systematic training of hospital administrators.

All through this analytical report which points out the various deficiencies and inequalities in the distribution of medical service to those who need it most, the Committee seems to put the entire burden upon the medical profession for the proper distribution of medical service. The Committee failed, in my opinion, to point out in no uncertain terms that the public, in many instances, either partly or entirely, is to be blamed for lack of adequate medical service. It would have only been fair to the medical profession for the Committee to have pointed out that, in the past as well as in the present, the profession was and is still bearing the major burden of giving free medical service to those who can not afford to pay for it; and since the medical profession has done its share, it is now the duty of the public to seek a way out of its difficulties by some form of insurance or personal thrift, which would provide the necessary financial means to pay for medical service.

As you know, there are 2 *Minority reports*. The first, was signed by 9 of the dissenting members, and the second was signed by 2 of the members; and there is also a separate statement made by 1 member of the Committee.

Those who signed the first minority report believe that group clinics are in the line of progress but they should be a natural outgrowth of local conditions. That compulsory group clinics would lead to restriction of freedom of action in respect to location, study and travel, publication of medical articles, etc.

The minority group are not entirely favorable to industrial medical service, although they do not definitely oppose it. They claim that voluntary health insurance failed everywhere. It would give rise to destructive competition among professional groups. It would bring about inferior medical service and demoralization of the profession.

The group *opposes compulsory health insurance because* it would bring about soliciting of contract through lay promoters, hiring of doctors by laymen and lower standards of practice. They are vigorously opposed to the corporate practice of medicine, financed through intermediary agencies. They are in favor of the county or medical society plan for medical care in which all medical cost and the responsibility of the medical care of the entire community will rest with the medical profession. This would remove the possibility of unethical competition, such as solicitation of patients, underbidding for contracts, etc.

The second minority report is practically in agreement with the first. It condemns the medical center plan as a utopian concept, "too visionary or problematic to justify inclusion in an authoritative report of this kind". The signers of this report *do believe in compulsory health insurance* and professional control.

The essence of disagreement between the dissenting groups seems to be based on the following point: Shall the reform in medical practice come from the medical profession itself, or shall it come from a non-medical source?

Whether one agrees or disagrees with the *Report* in all its details or in part, is beside the point. It certainly points out in a definite and clear manner, all the various deficiencies

in the character and distribution of medical service to the people. The fact that it does not offer a positive solution, which will meet with the approval of all those interested, does not detract from its value.

Any new departure from accepted standards, whether it be that of industry or commerce, education or art, governmental or other social institutions, is usually subjected to very severe criticism. Social changes are, and should only be, made after careful analysis of the proposed new methods, as to their practicability and applicability, to that particular branch of our social economic system which we propose to change.

The medical profession has always served humanity in an altruistic manner, up to the present day. In its miraculous scientific progress during the past 50 years—a period during which one brilliant epoch-making discovery has followed after another—there is not a single example of greed, selfishness or commercial tendency. All the great revolutionary medical discoveries by which millions of lives have been saved and an endless amount of suffering alleviated, were cheerfully given to the world without expectation of any reward or even of public acclaim. Hundreds and thousands of physicians are constantly working in the obscurity of their laboratories trying to solve, and slowly actually solving, many other medical problems.

Read the scientific transactions of our national, or even the local medical societies or hospital groups, and you find the dominating note of all is that of sincere devotion to advancement of the art and science of medicine. The advances made in medical education, the establishment of higher standards of hospital service or health agencies, the reduction of infant mortality, the fight against the ravages of tuberculosis—all came from within the ranks of the medical profession. It was not brought about by a special legislation or through public exertion. It was brought about through that inner medical conscience which motivates the leaders of our profession, constantly urging them on to further progress. It is this scientific and professional group conscience, permeating the medical profession, which is responsible for modern medical progress.

Sudden socialization of medicine may lead to some unpleasant sequels. Medicine occupies too important a place in our social organization to permit of drastic, sudden experimentation or radical changes in its present organization. What is most needed is public education with respect to its own responsibility to the cost of modern medical service. The complete destruction of our present system, and the substitution of a paternalistic form of medical service, is certainly not practical at present. Relief will surely come through a slow, progressive evolution from within our own ranks, by adapting the most desirable features of our present method to the changing trends of all the other factors of social organization.

It is almost utopian to expect that medicine can be socialized, while all other human activities continue to function on an individualistic pattern. So long as the underlying base for most of our activities is the expectation of material reward, it is hopeless to expect that the profession of medicine is ready to function on an idealized social form.

Undue pressure from without may result only in strong resentment, disorganization and retrogression, with all its concomitant ill-effects and, in the last analysis, the public will suffer thereby.

ONE OF THE MEDICAL ECONOMIC PROBLEMS IN NEW JERSEY*

William Rowland Davies, M.D.,
Scranton, Pa.

I am going to talk about the one part of our affairs about which we complain the most and do the least to remedy. No one knows better than you the altruism and spirit of self-denial that makes the practice of medicine what it is today. At the beginning let me say that I hope that nothing I may say will induce the doctor to lower his standards of

*(Read before the Woman's Auxiliary to Somerset County Medical Society meeting of October 1932.)

ethics. I do hope, however, to so startle him that he will take his head out of the clouds for a while and pay a little attention to the cure of some of his own economic ailments.

Within the lifetime of some who are present, it can be recalled that the whole economic situation of practice revolved about the doctor who called when sent for, did whatever his capabilities allowed, and furnished the medicine or wrote a prescription; the nursing was a family affair. The doctor charged a fee which was paid or not, as conditions allowed, and the circle of the event was closed. The doctor was the important and only expensive feature of the occasion, and the results were just as good as the times provided.

The fee charged was one commonly accepted as being the sum necessary, when prorated over the community, to cover the cost of keeping a physician in that community. The cost of producing a physician was nominal and the cost of maintaining him was but slightly above the common human average. The doctor's intellectual attainments were in keeping with the information that he was able to acquire by his opportunities in the times in which he lived. He served in his restricted way as well as circumstances allowed. He could be improved. He finally was improved, and with his improvement came the great advancement in all the branches of his service.

The medical profession has brought about all of the improvements and benefit that its kind apply for the good of the race by its own initiative and ingenuity and without popular demand. These advancements are necessarily expensive but cannot be dispensed with if the system is to continue. The whole system of medicine and surgery has been so beneficial to civilized people as to double the lifetime of human beings. It cannot be abandoned.

I propose to talk about the economic state of the modern doctor, for, in devising all of the benefits of improved and expensively produced doctors, with the increased cost of their living and equipment, scientific and costly nursing, use of hospitals for all serious conditions, specialization, extensive laboratory diagnosis and technical treatment, attached to an elaborate system of public welfare; the doctor has done nothing to set his personal position in this scheme of things right with the public.

He makes his charges on the same basis as he did a century ago, except that he has voluntarily contracted his financial opportunities to make the accompanying expensive elements of practice possible. His was once the whole income for scientific service. Now it is divided in many channels. The part he receives is the matter for our present discussion.

It is of great concern that the economic side of practice is scarcely mentioned to students in colleges, and they are left largely to meet it uninstructed in practice. There is no standard textbook sanctioned by the profession that deals with the subject.

In localities, we at times prepare fee bills of so-called minimum prices; this is the sum total of our pronouncements to the public as to our relations with them in a business way. The public takes it for granted that we get these sums in every instance, or with few exceptions, and consequently we must be well compensated.

The fact is that we charge for an undesired thing in an undesirable way and at an unfortunate time, with some few exceptions. The ordinary family budget, if there is such a thing, does not provide for this contingency as a rule. It is looked upon as a calamity, topped off with a financial penalty which is to be avoided if possible.

The ability to avoid this responsibility has been made possible by the medical profession in 3 ways: (1) by preventing the occurrence of disease; (2) by fostering free public health agencies; (3) by making charges that only a small section of the people can easily carry.

The people themselves avoid the responsibility in 3 ways also: (1) by absolute inability to pay; (2) by plain dishonesty; (3) by being willing to accept free organized public services when able to pay.

There is a combined situation in which physicians knowingly, in their practice, afford free treatment or service to people or institutions who are able to pay and should do so—a sort of standard free list used to get

business or develop popularity. We are not altogether blameless.

The public does not understand that the medical profession is created and maintained as a public necessity entirely upon its internal resources. It is in few instances endowed, cannot lay taxes or appeal to public funds, has few subsidies, and yet covers the total public requirement by a hit-and-miss system of financing that is archaic and never in its history served fairly to cover its accomplishments.

As a profession, we are poor business people; we assume an attitude of lofty indifference. As individuals, we are to a man dissatisfied with the attitude of the profession as a whole; yet we may be satisfied with our individual successes, and there is the rub.

In trying to analyze this situation, I get almost nowhere by listening to the opinions of individual doctors. Whether financially successful or not, each one of you can arise and detail personal wrongs to be righted—a tale that will enlist the sympathy of all of your hearers if *their* particular complaints are righted first. I do get somewhere by a consideration of what we do as a profession, by an analysis of our activities as we serve the public, based upon what is required of us in our peculiar position in society.

Let it be distinctly understood, all quackish inroads to the contrary, that we enjoy a monopoly of the things for which we stand and do for the people; because we are the only class of people in the commonwealth who are sufficiently trained to carry on our particular function. We have no substitutes.

If, in our hearts, we are not completely sold on this proposition, then we have a weakness that makes our defenses difficult or impossible. As a profession we do not suffer from such an inferiority complex, however.

As a total system we are as correct as human endeavor, constantly at work, can make us. We fail only in the presence of the impossible or unknown, or by the ineptitude of individuals but not of the system. Our greatest failure is scored in not being understood correctly, commonly, by the people. Nothing that I tell you today will be of any value to you unless you share it and much more with the people by some system of public information.

Because of our monopolistic situation, we have a duty to perform for society. We must cover the total requirement. We must be prepared to serve, or assume the responsibility of service for, the total requirement, and I will show that we cover the function in an astounding manner.

The service that we control must be accomplished by our own free efforts on the one hand, or may be charged for on the other, but what we do charge must cover the cost of the whole procedure, as there is no other source of funds. Institutions may at times be endowed but the rank and file must achieve their own financial destiny.

No matter what our needs, it goes without saying that the desire to serve as well as possible is our first and foremost reaction. We want the opportunity to serve, and we go to strange ends to get the opportunities. Not knowing the power that our isolated position might give us if we chose to use it by centralizing our efforts, we engage practically as "free lances" (a rather apt comparison) and enter the activities upon our individual resources, and seldom appeal to our organizations for assistance or regulation in anything but the scientific side.

Changes in the times, and the ends to which we have carried an unnecessary generosity of service, are now forcing us to stop and take stock. The absolute necessity for having us is causing an itching on the part of the public to turn us into a State institution and "State Medicine" is a constant threat. Our peculiar type of generosity has made the people to think we are theirs to command, and if we are as helpless as they suspect, they may work their will in that matter. We are individually just that weak, but as an organized body we cannot be so handled. We have never exerted that power, but we may have to do so.

To be socialized or communized, or to have the stimulus of competition in thinking and action taken from us, is to most of us a doleful prospect. Yet we have out-communized

communism in a frantic attempt to avoid that very thing.

Our system includes such a large amount of service done for nothing and at our own expense, which we derive from that small portion of the population that can pay, that it would be folly for the State to take us over and try to run the function so long as we operate our affairs on the present basis.

My particular act in today's entertainment is to take a few available facts and figures and juggle them about a bit for your utter amazement. I will be at times approximate, at times average, and again quite accurate. My conclusions will be apparent to all.

I am a Pennsylvania physician but I can present New Jersey statistics with equal facility, as we are all brothers under the skin, and I shall get under your skins and you will not like it any more than I do, but it is a treatment that we all should take whether we like it or not.

Let us analyze a while. Rather ingenious methods have to be used to produce totals and percentages concerning the work that you and all of the rest of the profession in New Jersey accomplish. The enormity and variety of demands placed on you by the public will almost stagger your imagination. You cannot come at it by reports from you as of income and size and type of practice. You do not report the facts as they really exist. It is possible to get some idea of your service by noting the variety of demands made upon you for services that no one else but you can provide. Some basic unit must be admitted, and we will call that a contact. Let a contact be, then, any professional service required by any one person in one day as the unit by which we work.

The contact then includes anything from a major surgical operation down to the mere inspection of a person. It may include the services of several physicians or repeated calls in one day. All this is leveled off and included under the simple unit as a contact. The figures I will present average upon reports for the year 1930.

The population of New Jersey for 1930 is recorded as 4,041,334.

The best actuarial experience tables state that adult men average 6 days of disability annually, adult women 12 days, and there are no figures obtainable for children, but you know they must equal at least that of adult women. As we do not contact on every day of disability, let us take the lowest figure—6—as averaging for the total population.

Multiply the figure 4,041,334 by 6, and you arrive at the average number of disability contacts made annually by the doctors of New Jersey, which is 24,248,004.

You say that that is preposterous. Well, it is not. I have a substantial check on that figure.

You have in New Jersey 168 registered general hospitals, which include 33,470 beds for all purposes. The average daily usage of these beds is 25,233. The total annual usage, then, is 9,210,045 bed days.

How about the Out-Patient Departments and the Dispensaries of the State and cities? Careful scrutiny discloses that they have an attendance of twice the number of hospital patients, but require but 1/6 the number of contacts. This equals 1/3 of the bed contacts or 3,070,015. The total of hospital and dispensary disability contacts is, then, 12,280,060. Subtracted from the total as above—24,248,-004—you have remaining as outside contacts 11,967,944.

You accomplish a little better than ½ of the total enormous number noted in your hospitals and dispensaries alone. You have a little less than 3 contacts per person to account for in the total practice of the entire profession in general, special and office practice, not in hospitals or dispensaries. I believe that that reasonably checks the claim.

You have probably been thinking of what the value of that service would be if it was paid for. Let us figure it out. How can we come to a unit of value in dollars for the service? As the contact may include any service from a major surgical operation down to a simple call, let us put the figure at the bottom, and not even as an average, and call the contact of the same value as the present house call—$3. You arrive at the staggering total of $72,744,012. You must be doing pretty well in New Jersey.

But this is not all. What I have told you has to do with disabling illness and injury. What about contacting the non-disabling illness and injury, the social and health services, ect.? Let us list some of the things that we cover:

Teachers in medical colleges, pre-medical courses (doctors only), and training schools for nurses. Research workers.

Civil appointments in governmental health agencies.

The total of non-disabling disease and injury, house and office practice, met with in all lines of practice.

Telephone consultations.

Preventive practices by inoculations.

Periodic health examinations.

Life insurance examinations.

School children's examinations.

Workmen's health certification.

Non-hospital institutional supervision.

Pre- and post-natal clinics.

Well-baby clinics.

Health talks to clubs and gratuitous advice to individuals.

Red Cross instruction courses.

First aid taught to boy and girl Scouts, with examinations.

Physical examinations for students for college entry.

Child campers' physical certificates.

Positions as supervisors or directors in the medical departments of insuring concerns.

Medicolegal testimony.

Preventive medicine in general.

I may have forgotten a number but these will serve to illustrate the uses physicians are put to, to cover the requirements of the public outside of purely disabling disease and injury. Whatever expense of time or money these activities incur is paid for by whatever the doctor may get for doing them. To reduce them to contacts and put an average price upon them is impossible. However, they are all done at an expense of time, and that, with his ability, is all a doctor has to sell. You will admit that in the list submitted there are many well-compensated situations which, in the final audit, are included in the total income of the whole profession.

The law of diminishing returns works its largest element in some of the items stated. We know that the largest tax upon his time, if not his ability, is contained therein. Some of it is well compensated for and much not at all or poorly. At any rate it covers ½ of his available time or of the time total of his activities, but we have no way of checking it for our information. Let us set it aside for a while, while we produce some other figures.

Considering the financial situation of physicians in general, we know that a small percentage become wealthy after years of service. A larger portion arrive at the end of their lives with ample reserves. The vast proportion practice and live at incomes that simply serve to cover their peculiar necessities. A smaller proportion must get along under restricted circumstances. Those entering the profession actually go into debt until paying practice catches up with expenditures. If they pay their debts, it is not from money obtained from practice.

The average gross income of all physicians does not exceed $5000 per year as of pay for service rendered. Income from other sources has no bearing on this argument. If I am mistaken and it is higher, I am glad of it, but my personal inquiries bear out my statement; particularly since 1927, when ordinary funds began to be diverted to speculation, and markedly so since 1929, when the bubble broke.

At the rate quoted we can arrive at some conclusion as to how the State of New Jersey compensates the medical profession. You have approximately 4000 doctors, perhaps a few less, but it serves as the correct number upon which to base my statement. At the average income of $5000 per year, the entire income is $20,000,000 per year—an annual charge of $4.95 for each person in the State.

If you will now go back with me to the figure which we obtained at $3 per contact for proven disability contacts, which reached the number of 24,248,004 and produced the $72,744,012, and place it opposite the figure $20,000,000 as your entire income, you are not doing so well as you thought. If that is the total part of your practice that you are to be paid for, you are not getting $3 per contact.

The actual sum is 87 cents a service, which may include anything that 1 or more physicians can do for any disabled person in 1 day.

You also throw in for good measure all the non-disability practice, all preventive medicine, all social service, all teaching and research, all civil, political, and salaried insurance positions, and the multiplicity of gratuitous services for which no charge is made or expected.

This, my friends, is the service which, it is threatened, can be socialized or communized by the State to its own advantage. Let us go a little farther.

We have been dealing with physicians' incomes from the standpoint of the gross. The doctor's real income is what he has left after he pays the cost of doing business. Except in the cases of physicians enjoying unusually large incomes, and of those starting in practice, there is a straight line graph of the expense of doing business. It equals 1/3 the gross income. And $3333.33 is the average sum that goes into the doctor's mythical pay envelope to put over for his domestic requirements, take post-graduate courses, go to Europe, and educate his children. He is now down to 58 cents a contact as his real pay for disability service, and still manages to throw the rest in for good measure.

You will now note that at the lowest possible method of figuring the values, the doctor does 4 services, at least, for the price of 1 as gross, and 5 for 1 as net.

The question that at once arises is, what the ability of the people is to pay for anything above the bare necessities of life. The present depression has temporarily broken all previous experiences as a working factor, but time will change that or nothing will matter.

Whether we believe and like it or not, the medical profession admits a poverty level among the people which has no relationship to that which holds for other vital necessities, for it is much higher in scale. We admit that any person or family is eligible to free medical or surgical treatment which cannot, in due time and with credit extended, pay the ordinary costs of living if the added expense of illness or injury will prevent such payment. We voluntarily or involuntarily take that position as placing our charges just between normal costs and beginning luxuries. This is not a fixed figure but scales upward with the surroundings and habits of life of the individuals with whom we deal.

The Rosenwald table of income shows the following:

There are 46,000,000 producers of income in the United States.

6,000,000 or 14% produce less than $1000 per year.
13,000,000 or 30% produce between $1000 and $1500 per year.
18,000,000 or 35% produce between $1500 and $2000 per year.
6,000,000 or 14% produce between $2000 and $3000 per year.
2,000,000 or 5% produced between $3000 and $5000 per year.
1,000,000 or 2% produce over $5000 per year.

By this you will note that we have struck a strange economic balance, for 79% of the producers of income are at or below the $2000 per year mark. We have an admitted state of doing approximately 75% of our service for nothing; therefore, the poverty level in medical economics for the whole country averages on incomes just below $2000 per year.

The average is evident, for we know that many people above that level are not above taking service for nothing, and a rapidly dwindling number below that level seem satisfied to pay their way. The wonder is that we can impose the total charge for the service upon the 25% of the people who do pay, and have the system continue to exist.

These statements, of course, are average. We all know that the abjectly poor sometimes pay some fees, and at the same time we know that the very rich obtain elements of service at no cost. About 50% of the people are accepting charity at the hands of the medical profession who are, consciously or not, simply dead-beats, and this is what makes the high cost of professional attention to those who pay and now complain.

Now, what is the doctor's bill of particulars

as to why he should make the charges that he does? Arranging for the future, and not being influenced by past conditions that are gone for good, it must be admitted that the present-day doctor is expensively produced and at an expense of time and money that he cannot avoid. Before he finally qualifies to practice, he has had expended upon himself approximately $15,000 in money for his education and 10 years of uncompensated time between the ages of 18 and 28, which should be rated as worth $10,000, making a total investment of $25,000 which he should expect to regain in a reasonable number of years, outside of all other considerations. His equipment must be sufficient and be kept free of depreciation by proper upkeep. His manner of living, by common consent and popular demand, must be above the average. He should have normal rights to life, liberty, and the pursuit of happiness.

He has independently created himself for a service that has its spiritual compensations, but he is not the serf of either the State or the individuals who may think that his work alone should be his compensation. He has got to realize flatly upon his investment and the expense that he is constantly putting into the business. When and if Communism ever comes, he will be produced at the expense of the State, and will be sufficiently compensated to make him efficient, or his value will lessen to the vanishing point. Until that day arrives, he must be dealt with upon purely business principles that will justly cover the situation.

If it were made plain to the future student that he was to spend the equivalent of $25,000 before he was in any position to realize a cent upon his investment, and that little or none of his primary investment would ever return to him as return of capital purely independent of what he might expect from income from future service, he might stop to think that the mere interest on the sum invested would keep him free of want in a modest way all of his life, and any other activity would serve to add to his material state, and he might think twice before he made the venture.

Outside of the mere financial consideration, is there not some meed of praise or thanks that the people owe the medical profession for what they have done for them? At times the air they breathe, the water they drink, the food they eat, the streets they traverse, the place in which they work, or the house in which they live, has some element of safety in it placed there without cost or even thanks to medical science. The profession is constantly at work to eliminate the only conditions from which they expect a livelihood. The man of today lives a span of life almost twice as long as that before medical science found the way to stand off death by taking away so many of its grim reapers. His little children grow to maturity with fewer of the ills that once beset them, and their mothers pass the ordeals of their births in comparative safety, where once they died a horrible death.

All this is the free gift of the medical profession, to be had by all by the application of knowledge which is free to all who will take the simple trouble of learning its application.

The absurdity of it is that these things pass almost unnoticed, but Congress is asked to appoint a commission to consider seriously for 5 years the "Costs of Medical Care", with the inference that they are too high.

After all it is a greater absurdity that, after the profession has accomplished all its required study, goes on to added research, teaches prevention and cure of disease, applies its benefits to every walk of life and human endeavor, that it must be measured by the fact that in the remote and last position of their activities, when science and prevention have not availed and disease has occurred, they there apply the principal commercial element of their total activities in pay for treatment.

The opportunity to place a financial penalty upon misfortune is the rod by which we are too often measured, not the good which we do; and this little corner of our activities, in the last stage of the whole system, is the one and only part that the quacks and charlatans want a part in. Selling treatment for money, to people who know nothing more about our sciences and system of activity than that one point, places us on a par with any quack who does that trick, in their opinion.

The greatest teacher of ethics that ever walked this earth preached his total gospel openly, and sold it by a program of publicity and not of secrecy. He condemned keeping the light under a bushel. The medical profession is an established scientific human necessity, or it is a horrible parasite grafting upon human frailty and suffering. If it is right, it can sell its total gospel without fear or favor, by a program of publicity.

As it is a service that transcends the mere mundane, it has moral and spiritual qualities. We must make the people understand and believe in us, and therefore respect and finally love us. Then nothing else will matter.

I believe this is largely accomplished but not definitely—not definitely because we have much yet to tell the people for their information as to the correctness of our moral and intellectual position as a profession, although we may here and there, as individuals, fail to attain the heights of ethics and intellect that the system we try to follow sets as a standard.

The scriptures state that "All that a man hath will he give to save his own life", but that refers to what he will give to a lawyer and not to a doctor. The farmer may not expect to be paid the whole charge made for his crops to the ultimate consumer. The collateral charges must be laid on after his are determined, and the final price may not be one that will make the payment for other necessities of life impossible, if the normal cycle of economics is to be accomplished. The price for a necessity is not what the traffic will bear in the last analysis but what it can bear fairly and allow all other similar situations to exist. Basically it should be understood that in good times or bad, business is always averaging the same for the total profession. In good times it appears as paid-for service to a large section of our numbers. In poor times it crowds the agencies established for free service to the people also served by us. Some serving section of the medical profession is busy at any time.

Our peculiar type of liberality, unknown in any other profession, stimulates the cupidity of people in times of stress such as the present to needlessly crowd the free services.

As we are basically humanitarians, we agree to stretch the mantle of charity to the breaking point, but what we do for nothing cannot appear in the bookkeeping to our credit. The cost for the service must be passed on to those who do pay. We have no other source from which to cover. This source has now become too small. As we do things differently than others, we cannot cut and cover requirements. We really should raise rates if we are to remain efficient. This, however, cannot be done in the face of existing conditions. We have 2 alternatives. We can turn our free service over to the community to pay for—and to whom they belong by a showing of the conditions as they actually exist—or we can by organized resistance put back on a paying basis the 50% of the population who are able to pay a reasonable charge but who are parasites upon our generosity. In either alternative, if successful, we can materially lower rates and be better off.

I believe I have shown clearly that out of 4 purely disability contacts we are paid as of 3 free to 1 paid. The one covers our entire income. Throwing in the total of every other type of service we are called upon to perform for which we are really paid a fair proportion, it finally arrives, by the lowest means of computation, that we are practicing at a 5-1 basis, and we should go to the public for an understanding.

We have unconsciously produced a serious misunderstanding in the minds of the people as to what their rights and privileges are and we, only, can start the rapprochement.

Charity is a thing of the heart, and is an individual, kindly reaction to relieve an unfortunate situation when and where found. We all can find plenty of it in our personal contacts which it is our pleasure and duty to do.

The present state of affairs is that, with or without our agreement, a condition of affairs has arrived which does not have a thing to do with our personal charities. It is a method that has grown to serious proportions for the purpose of the free distribution of medical attention, ostensibly said to be charity, but it is not. It is organized, however, and hands us the services in wholesale lots and deals with economic levels and not with the sweet spirit of the thing. Neither does it

concern itself with the problem of how the medical profession can carry it, even though they know that in the majority of instances we have to foot the bill, which is the better way to explain our situation than to eternally talk about doing things for nothing. We do these things at our expense and not for nothing.

We must take over the control of these agencies by appearing in sufficient numbers upon the Boards to be advisory at first hand. We have got to get back to first principles.

The "Good Samaritan business" was placed upon a correct working basis when the hero of that "Parable" had found someone by the wayside who had been beaten and robbed and left as dead, and did the obvious thing about it. He sensed the fundamentals of "who was his brother's keeper" and produced a demonstration of practical charity previously unheard of and not since improved upon. Being of a practical turn of mind, and the needs being plainly evident, he turned his donkey into an ambulance, did what first aid his intelligence permitted, and turned the first hotel that he came to into an emergency hospital; and then began to think out ways and means for the success of his venture. This he did by financing the project and hiring the work done that he could not do himself. He even anticipated unusual expense and provided for that. Nor does the story say that he called in the doctors and asked them to work for nothing on his pet project. It does plainly intimate that he paid the whole shot, for which he travels down the ages as the correct exponent of how such things should be conducted.

He climaxed the story by closing up his institution with a total experience of one patient only, so that the rest of the population might not rush in and graft upon his generosity—being a straight thinking person, he could see the possibility of easily overdoing the matter.

Analyzed, he showed that charity is an individual thing, to be handled when and where it is found, sensibly and sufficiently and as an individual proposition. He did not pauperize any particular level of the population as a fixed policy.

In that parable, there was but one donkey who was forced to accept an unusual and uncompensated load without considering its rights or feelings in the matter. In the modern exposition of charity, we have a second jackass interposed, and that is the doctor who carries an unusual and uncompensated load—not occasionally but constantly—which the people gladly let him carry. He has not yet let it be known that donkeys even can refuse to carry too large a load.

A CASE OF OSTEOMYELITIS OF THE JAW IN A NURSLING

Vincent Del Duca, M.D.,
Camden, N. J.

To Schmiegelow belongs the credit of interpreting the various manifestations as due to an osteomyelitis of the maxilla. In addition to the septicemia, which is a fairly constant occurrence, there are 3 cardinal groups of symptoms, each referable to the respective surfaces of the maxillary bone: (1) edema, cellulitis, and frequently abscess formation of the face, eyelids and tissues of the orbit; (2) copious discharge from the nostril of the same side; and (3) periosteal swelling of the alveolar process of the corresponding maxilla and suppurating fistulas, and later shedding of the deciduous teeth and teeth-buds.

Most authors consider this type of osteomyelitis as primary, explaining the fixation of the process to trauma incident to delivery, or to injury of the mucous membranes when cleansing the mouth. The essential pathologic process is a thrombo-arteritis or thrombophlebitis of the internal maxillary vessels or their branches; the amount of total involvement, in turn, depending upon the localization of the embolic process.

In the diagnosis, the following conditions are to be differentiated: (1) ophthalmia neonatorum; (2) dacryocystitis; (3) erysipelas; (4) syphilis and tuberculosis; (5) necrosis of the jaw due to phosphorous poisoning; (6) necrosis following acute infections.

The high death rate is due to the septi-

cemia, which is almost always severe. Many cases recover, but in almost all of these, we have a permanent disfigurement of the face, from loss of both the deciduous and permanent teeth.

Treatment: The general treatment is palliative. The local treatment is conservative. Drainage should be adequate, and sequestra removed when abundant involucrum is present. The operative procedures should, if possible, be always carried out by the intra-oral route, in order to prevent scar formation of the face and lids (ectropion).

Case report: L. E., female infant 3 months of age, was admitted to the children's ward of the Cooper Hospital on October 26, 1932, with chief complaint high fever and swelling of the right upper and lower eyelids. She was born at term and weighed 6 lb., 14 oz. Since birth, has been thriving normally, although it was necessary to place her on modified cow's milk formula. Three days before admission, the mother noted that the child was very fretful, and appeared tender in the region of the right ear. On the following day, both lids of the right eye began to swell; there was a discharge from the right ear and nostril.

The physical examination on admission showed a very toxic child, with temperature of 103.4°; marked swelling and redness of right eyelids; chemosis of bulbar conjunctiva. Dr. James S. Shipman, the ophthalmologist, further reported: "O. D. shows marked proptosis of the globe, limited ocular rotations and eyegrounds. The disc swollen about 2-3 diopters, and is quite pale. This case suggests orbital cellulitis." Right nostril was somewhat distorted and exuded a thick creamy discharge. Right upper gums were swollen and showed beginning necrosis. There was a small sinus at the site of deciduous right lateral incisor tooth. Right ear showed moderate discharge, left ear drum was slightly reddened but otherwise normal.

Laboratory findings: Blood, W.B.C. 31,250; neutrophiles 57%; lymphocytes 36%; large mononuclears 4% and transitionals 3%. Mantoux test, using 0.1 mgm. O.T., was negative. Pus from sinus in the mouth showed staphylococcus aureus and non-hemolytic streptococcus.

For 7 days the child's condition continued critical. On the eighth day of her stay in the hospital, she began to show marked improvement. The eye signs showed corresponding improvement; nasal discharge continued; aural discharge lessened. The mouth showed 2 sinuses about canine and lateral incisor teeth. A loose tooth could also now be seen, and there was extension of the swelling to the hard palate. On November 9, Dr. Anthony F. Gorham extracted the loose lateral incisor tooth and enlarged the sinuses of the mouth to promote adequate drainage. The child continued to improve, and on November 15, she was discharged in very good general condition. The right ear was normal. The sinuses about the alveolar process persisted, and showed thin purulent discharge.

Comment: The typical symptoms and signs in this case leave no doubt as to the diagnosis. Unfortunately, it was impossible to properly evaluate the rôle of the otitis media in relation to the osteomyelitis. Trauma incident to the face presentation was probably the factor predisposing to fixation of the infection to the jaw.

TREATMENT OF LEUKORRHEA

A. Shulman, M.D.,
Associate Gynecologist, Barnert Hospital,
Paterson, N. J.

It is not necessary to apologize for selecting this apparently trivial symptom for discussion. It frequently causes much more annoyance and aggravation than most male physicians realize.

By definition, leukorrhea refers to the presence of any abnormal discharge, other than blood, from the vagina. In discussing its treament, we must classify the causes, since treatment depends to a large extent upon the etiology, and in general, the causes may be considered as constitutional and local. In the first class are such conditions as diabetes, constipation, obesity, endocrine disorders and sec-

ondary anemias such as those due to tuberculosis, nephritis and poor physical hygiene. Such conditions must be looked for, and cure depends upon their successful treatment. In addition, certain local treatment is advisable. For example, a patient consulted us because of leukorrhea of many years' duration. Locally, she had only a simple, non-specific vaginitis. Constitutionally, she was of the long, stringy type, pale, always tired, frequently up late at parties, nerve force easily exhausted. With rest, high caloric diet, and ordinary tonics, she was cured in 6 weeks with comparatively little local treatment. Another type that often comes to the hospital is the patient with simple obesity, who needs only weight reduction and some local drying treatment; or her sister, who, in addition to obesity, has long periods of amenorrhea, male-type distribution of hair, and sterility. The cause is probably pituitary or combined pituitary and thyroid dysfunction. Once in a while, thyroid and anterior pituitary extracts seem to help these patients.

In considering local causes, we think of those above, in, and below the cervix, some of them being interrelated. Above the cervix, common conditions causing leukorrhea are ovarian tumor, chronic adnexal disease, fibroids, carcinoma of the fundus, subinvolution, and retrodisplacement of the uterus. I want to remind you to always regard the appearance of a watery leukorrhea in a woman over 40, which had not previously been present, as a suspicious symptom, even though there has been no abnormal bleeding. It frequently means that the patient has carcinoma of the fundus.

The most frequent and common cause of leukorrhea is chronic endocervicitis, with or without erosion of the cervix. Most frequently this condition is postpartum or postabortal in origin. Often it is gonorrheal, and sometimes non-specific. It is characterized by some thickening of the cervix, the presence of considerable tenacious mucopurulent discharge, reddening, erosion and eversion of the cervical lips. Frequently the earliest symptom of carcinoma of the cervix is the development of an irritating, watery leukorrhea, often without bleeding. Not long ago, a patient was referred to me for urinary incontinence. Close questioning revealed that she had a profuse, watery discharge without bleeding. Examination showed an advanced, cauliflower carcinoma of the cervix.

Ten years ago, we were taught that 95% of cases of leukorrhea were due to endocervicitis, and the remainder to the general causes outlined above, with an occasional case of vaginitis. Today that statement is not true. A large proportion of cases are due to vaginitis, both specific and non-specific. By specific, I refer to the vaginitis associated with gonorrhea, and that due to Trichomonas vaginalis. Many patients have definite vaginitis without definite etiology. Among these are to be classed the cases of senile vaginitis and those due to frequent, often unsatisfied, sexual excitement.

Treatment. Endocervicitis. Most cases can be cured by use of the fine, nasal-tip cautery. The cervix is exposed in a bivalve speculum; the discharge cleaned out; the cautery point heated to a cherry-red color; and a radiating series of stripes, about 1/16 in. deep and 1/4 in. apart, laid down from within the cervical canal to the edge of the erosion or eversion. During the first 10 days after this procedure, there is usually considerable increase in the discharge, which then gradually subsides, so that by the end of 4 or 5 weeks, the patient is free of symptoms. Occasionally, a second or even a third treatment is necessary in the areas between the first series of stripes. Nabothian cysts may be punctured by the same means; though puncturing them is not enough, and we should endeavor to cauterize the entire cyst wall.

This method of treatment will care for most cases of endocervicitis, particularly those of the postpartum type, but there are many cases in which the infection is chiefly present in the canal, with comparatively little erosion and eversion. Some of these are due to old gonorrheal infection and are better handled by electrosurgical conization of the cervix (Hyams' method). The entire mucosa of the cervical canal is coned out by the surgical diathermic knife to a depth (as a rule) of about ¼ in., leaving the muscle exposed. This re-

moves practically all the infected tissue. In about 4 weeks, the entire area is covered with soft epithelial tissue, and the cervix looks almost nulliparous. Until the advent of electrosurgical conization, most of these patients required Sturmdorf amputation, with its attendant inconvenience, hospitalization, anesthesia, etc. One had also to consider the possible difficulty with cervical dilatation in subsequent labors. On the average, the result and appearance of a cervix treated by conization is much better than that following surgical amputation.

We come next to the treatment of gonorrhea. This has always been difficult, because of the peculiar anatomy of the cervix, with its compound racemose glands, and because of the frequent localization in Skene's and Bartholin's ducts. Topical applications and irrigations have some effect upon the surface infection, but cannot reach into the depths. A new treatment has been developed in the past few years—the Elliott machine. This is a method of producing intense heat in the pelvic genitalia. It consists of introduction of a distensible rubber bag into the vagina, through which water may be pumped at a constant pressure, and at a temperature up to 130°, which is easily tolerated by the average patient. Because of the intense heat, there is marked dilatation of the blood vessels, with attendant exudation and improvement in the drainage of the glands, plus direct bactericidal action on the gonococcus. At Bellevue Hospital, on Professor Holden's service, they feel that this is the best therapeutic measure available. The following case history is an example of its usefulness:

In March 1932, I saw first a girl of 18, who complained of marked leukorrhea of 3 weeks' duration, urinary frequency and urgency. She denied intercourse. Examination showed urethral and vaginal discharge, vulvovaginitis, and an intact hymen. Smears were positive for gonococcus. Because of the intact hymen, I did not immediately begin Elliott treatment. She was treated by autogenous vaccine, and protargol irrigations of urethra and vagina. A Bartholin abscess developed, which ruptured spontaneously. Symptoms improved, but she had a moderate amount of persistent discharge, and the smear remained positive. Finally, in desperation, Elliott treatment was instituted, 4 months after the patient was first seen. Treatment was given 5-6 times a week for about 3 weeks. The discharge ceased, smears became negative, and have remained so ever since, even after menstruation. The Elliott method is useful in many other pelvic disorders, with which, however, we are not concerned here.

Vaginitis. It is only in recent years that gynecologists have become aware of the frequency and importance of the organism, trichomonas vaginalis, as a cause of vaginitis and leukorrhea. The characteristic clinical symptoms of this infection are a rather profuse, thin, gray-white leukorrhea, plus a moderately intense pruritus. Examination shows an irritated vulva; reddened vaginal wall, with discrete spots of bright redness, much like the tongue in scarlet fever; thin, milky, discharge in the vault, containing tiny bubbles of air; and, very often, a cervix showing small, irregular areas of erosion not connected with the cervical canal. Examination of a drop of secretion, diluted with a drop of saline solution, under the microscope, shows many polynuclear leukocytes, a fairly large number of epithelial cells, and fewer or larger numbers of the organism, Trichomonas vaginalis. It may be recognized by its active motility. Often, it will be found beside or under a clump of leukocytes, which are being agitated by its activity. Except for its motility, it looks much like a small epithelial cell.

There have been many types of treatment described for this condition. My best results have been obtained with the following method, given in the office about 3 times weekly: Through a bivalve speculum, the vaginal secretion is wiped out. The vagina is thoroughly scrubbed with green soap and water, making sure to go over the entire mucosa, flushed with warm water, and dried. The mucosa is painted with an antiseptic, such as 5% mercurochrome or 2% silver nitrate. The vagina is dried again, and packed with a warm, Lassar's paste tam-

pon. This is left in until the patient returns for her next treatment. In about a week or 10 days, the symptoms will have almost entirely abated. When this occurs, I usually use, instead of the Lassar's paste tampon, a dry powder containing 1 part sodium bicarbonate, and 3 parts kaolin, held in place by a dry tampon. This is removed in 24 hours, and a 5% lactic acid douche given. The patient is instructed to insert a picric acid suppository each night; that is, if she has no tampon in her vagina. After about 4 to 6 weeks, a final treatment is given, consisting of carbon tetrachloride, 50%, in olive oil, which is instilled into the vagina, swished around, and also applied to the external genitalia. The patient is then discharged with instructions to take a 5% lactic acid douche daily for about a month, and to insert a picric acid suppository 3 or 4 times a week:

Nonspecific vaginitis. Frequently, we see a patient after the menopause with considerable discharge, sometimes slight bleeding, and an atropic vagina. These cases can be markedly improved by treating the vaginal mucosa with full strength pyroligneous acid, followed by powder and tampon, 3 times weekly for 2 of 3 weeks.

Finally, we often see patients with watery leukorrhea, and a moderate degree of vaginitis. Trichomonas is not present. Other causes are not found. These patients may usually be cured by the so-called Nassauer or "dry" treatment. The patient is placed on the table in slight Trendelenburg position, the vagina is filled with the dry powder mentioned above, and a small dry tampon inserted. If possible, it is retained for 36 hours. Treatment is repeated 3 times weekly for 2 weeks. Then the patient is given a Holden powder blower, shown how to use it, and told to use it (using the same powder) for 2 or 3 weeks longer. This is usually sufficient. This powder method is also helpful in the cases due to consitutional disturbances, mentioned earlier in this paper.

MASTOIDITIS: A DIFFERENTIAL DIAGNOSIS

Henry Dintenfass, M.D., F.A.C.S.,
Philadelphia, Pa.

This symposium is presented with the hope that a better understanding of mastoiditis will be established and so prevent many of the pitfalls and errors in diagnosis of this disease.

Mistakes in diagnosis of mastoid disease, while not common, do occasionally happen, not only in the general practitioner's routine but in the otologist's as well. The opinion is current that too many mastoidectomies are being performed, both in cases simulating mastoiditis though not mastoidal in origin, and in those where there is some mastoid pathology but where recovery could ensue without surgical intervention. On the other hand, it is true that diseased mastoids have been overlooked and serious complications resulted.

In briefly reviewing the etiology of mastoiditis, it should be emphasized that with few exceptions mastoid disease takes its origin from the middle ear. The mastoid cells are intimately connected by means of a doorway, the aditus, with the tympanic cavity. This cavity in turn communicates with the nasopharynx through the eustachian tube. Thus infection from the nose may be easily carried to mastoid cells. This is especially true in infants and children, as they have shorter and wider eustachian tubes than adults.

Mastoiditis, like other inflammatory diseases, may be classified as acute and chronic. In acute mastoiditis there are 2 pathologic types: (1) the hemorrhagic or virulent type, in which there is inflammation of the mastoid without the breaking-down of the intracellular walls, and which shows little tendency toward localization or formation of pus; and (2) the coalescent type, where there is a disintegration of the cellular walls with localization and formation of pus. In this type, the infection is usually not severe. In chronic mastoiditis, the pathologic changes are such

that a sclerotic character of bone results. In addition, there may be found epithelial-like masses, cholesteatoma, the presence of which is a constant menace. It is readily seen, therefore, that the symptoms and signs of mastoiditis depend largely upon the type of pathology present.

In discussing the symptomatology of mastoiditis, we will reverse the usual sequence, and consider first the most frequent cause for confusion in diagnosis—swelling.

Swelling in the mastoid area is not always of mastoid origin. It may be caused by a furuncular condition of the external auditory canal wall, or by lymphadenitis. A furuncle may produce swelling in front of, above, and behind the ear, thus simulating a mastoid condition. Even though pressure over the tragus and lifting of the auricle produces pain, if a view of the drumhead discloses it as normal, the suspicion of mastoid disease is eliminated. Often, proper inspection of the tympanic membrane, because of a narrow auditory canal, may be impossible. Lymphadenitis also resembles mastoid swelling, at times, by producing retro-auricular swelling and swelling below the ear. Diagnosis may be difficult if an acute otitis media exists. Absence of a sagging posterior canal wall, and careful palpation of the gland area, will usually exclude mastoid pathology. Occasionally these glands break down, and while the pus formed is always external to the periosteum, the difficulty in recognizing the real condition is increased.

Swelling of the mastoid area, which originates from mastoid pathology, may take place in one of several locations.

The immediate retro-auricular region is the most common site, where swelling may cause the ear to project from the head, and may obliterate the normal creases behind the ear. This occurs particularly when pus has broken through the mastoid cortex and resulted in fistula formation.

The next most common site is the zygomatic area in front of the ear. This swelling often simulates mumps; extreme tenderness over the zygomatic process usually clinches the diagnosis. Recently, we saw a child being treated for mumps because of swelling in front of the ear. A moderate amount of discharge exuded from the external auditory canal, and there was a distinct tumefaction in the parotid area. Tenderness over the zygomatic process was disclosed and mastoid pathology, therefore, suspected. A mastoidectomy revealed a much diseased mastoid as the source of the trouble.

Swelling of the mastoid tip is also fairly frequent, due to a walling-off of the tip cells, with consequent fulness in the tip area.

Mastoid swelling can make its appearance as a tumefaction in the tissues of the neck, and in this form is known as Bezold's abscess. This is the result of mastoid infection breaking through the tip cells of the mastoid process. I can recall an instance in which a diagnosis of lymphadenitis was made, and where ointments of various kinds were applied to the swelling in the neck, before a careful examination revealed the true nature of the trouble.

Swelling caused by mastoid disease occasionally invades the occipital bone. At first sight it may seem to have no connection with the mastoid, appearing as a "lump" in the occipital region. That a mastoid can occur in this form should be remembered. A case of this kind was reported by the speaker to the Philadelphia Laryngological Society in 1923.

In the types of mastoid swelling just mentioned, the coalescent variety of mastoiditis predominated; the cortex is unusually thin, with frequent fistula formation.

Mastoid swelling may occur in conjunction with acute otitis media in the first several days of the affection. This does not always necessitate operation, since with adequate drainage from the middle ear, and hot aural douching, the swelling may subside and recovery ensue. This is the kind of case in which operation is apt to be performed too early, without giving nature a proper chance. The fact that pus may be found in the mastoid cells at operation does not mean that a mastoidectomy was imperative.

Mastoid disease may exist with little or no swelling. In this class can be placed many of the mastoid cases. The swelling may consist

of a slight thickening only of the periosteum over the mastoid, or possibly an obliteration of only one of the retro-auricular creases, or there may be a complete absence of swelling. Our attention is drawn to the ear, and the diagnosis of mastoid disease made by other symptoms which may appear singly but are usually in combination. They are herewith described:

Pain. This is the principal symptom in all cases. It varies from a short, stabbing pain in the early stages of the condition, to a dull, boring pressure after the disease has become established, and is always greatest at night. Pain over the mastoid at the beginning of middle ear abscesses has no particular significance. An acute otitis media associated with headache, pain behind the ear, and in the cheek of the afflicted side, is always suspicious of mastoid involvement. A continuous occipital pain or headache, during the course of an active middle ear of mastoid disease, suggests meningitis. Pain in the ear and over the mastoid process may also be referred from a sphenopalatine affection, (Sluder's syndrome) or an impacted tooth. Surgery of the mastoid has actually been performed for these conditions when no pathology in the mastoid was present. Injury over the mastoid may, in neurotic individuals, cause persistent pain, and result in a mistaken diagnosis.

Tenderness. This sign is elicited by applying digital pressure over the mastoid antrum, mastoid tip, or over the emissary vein (about 1½ in. back of the external auditory canal). In many cases of acute otitis media, tenderness over the mastoid tip is exhibited during the first few days. If tenderness persists after the first week, it indicates trouble. Tip tenderness is the usual location in the average mastoid, but tenderness over the emissary vein is especially characteristic of deep and serious mastoid involvement. Tenderness may be extreme in the thin-walled cellular type of mastoid, but when the mastoid cortex is very thick and sclerotic, it may be entirely absent, even though much mastoid pathology exists.

Temperature. There is always some elevation of temperature in the beginning of a diseased mastoid. In the virulent, hemorrhagic type, the temperature remains high, about 103° or 104°. An up-and-down (steeplechase) temperature associated with chills is highly significant of a blood stream infection. In the coalescent mastoid, after localization of the pathologic process has occurred, temperature may drop to normal, or nearly so, and stay there. An absence of fever does not, therefore, contra-indicate a diagnosis of mastoid disease.

Sagging of the canal wall. In certain instances sagging of the posterior canal wall, near the tympanic ring, may be the only evident symptom. This is due to a periostitis, the pathologic process extending forward and impinging on the external auditory canal, and is frequently seen where no retro-auricular swelling is present.

Character and amount of discharge. In the absence of a furuncular condition, a creamy discharge, particularly if profuse, is significant of bone involvement. Much discharge indicates that it comes from some other source than the middle ear. Following an acute otitis media, the discharge is at first serous or serosanguineous, later becoming purulent. A foul smelling discharge accompanies chronic mastoiditis, particularly when cholesteatoma is found. Cessation of discharge, with increasing symptoms, indicates blocked mastoid drainage.

Appearance of the drum head. In infants there is no bony canal. Only a movable, fibrous canal is present, which seems almost closed. In order to view the drum head, the auricle must be pulled downward and backward, where in adults the drum head may be seen by pulling the auricle upward and backward. A normal drum head is pearly gray in color, slightly translucent, and somewhat retracted; in mastoiditis the drum head is usually reddened, bulged, and often shows a perforation which is nipple-shaped in character. This type of perforation indicates that the secretion in the middle ear is under pressure. The necessity for repeated paracentesis of the tympanic membrane is a bad sign, and usually means that surgery of the mastoid is essential. A perforation in Shrapnell's membrane is almost always indicative of chronic attic suppuration. When the tympanic mem-

brane is opaque or has a ground-glass appearance, it discloses that all is not well within the middle ear and mastoid process. This is the kind of drum head one sees in so-called latent, or atypical mastoiditis, and has been frequently spoken of in connection with infantile diarrhea, where the mastoid is acting as a focus of infection, without frank symptoms of mastoiditis.

Facial paralysis. The occurrence of facial palsy on the afflicted side, in the course of an acute or chronic otitis media, is pathognomonic of mastoid disease, and calls for immediate surgical intervention. The presence, too, of paralysis of the external rectus muscle (sixth nerve paralysis—Gradenigo's syndrome) generally indicates a surgical mastoid. Both of these varieties of paralysis in conjunction with mastoid disease have been previously reported by the speaker, and by many other otologists.

Vertigo and dizziness. These are occasional symptoms, and may mean an irritation of the labyrinth from the toxins, or an acute extension of the disease to the internal ear. They may occur in acute as well as chronic mastoid conditions.

Deafness. Impairment of hearing of the affected ear may be the chief symptom of the so-called "atypical" mastoids, when the drum head is apparently normal and no other sign is present.

Blood examination. There are several advantages in having a blood count. A high leukocyte count shows good resistance; a high polymorphonuclear count indicates a severe infection; a high lymphocyte count shows a tendency toward chronic infection; a high eosinophile count, more than 400 to the cubic millimeter, may mean localization of the pathologic process; a gradual reduction in red cells, with a corresponding diminution of hemoglobin, indicates a hemolytic process.

Microscopic examination of the ear discharge. This is of definite value only when done early; otherwise contamination of the causative organism has probably taken place. Hemolytic streptococci produce the most virulent infections by entering the blood stream. Other streptococcic and staphylococcic organisms are less dangerous.

Roentgenography gives information regarding the size of the mastoid, position of the lateral sinus, and condition of the intracellular walls. If the intracellular structure is intact, notwithstanding the presence of an exudate, operation can be deferred. If breaking-down of the cell walls occurs, operation is indicated. In the final analysis, however, radiograms should supplement and not substitute for other clinical findings.

Rigidity of the neck. In children and infants, signs of meningitis and meningeal irritation may occur coincidently with the mastoid symptoms. This is due to the continued patency of the petrosquamous suture. Unless actual meningitis is present, these signs disappear as soon as the mastoid has been drained.

Presence of choked disc. This sometimes occurs in mastoid disease and may simulate a brain abscess when few mastoid symptoms are found. I have had one such experience, a patient referred to me by Dr. Grant, of Philadelphia, who disclosed the chronic or sclerotic type of mastoiditis with cholesteatomatous formation. Following mastoidectomy, the eye returned to normal in about 5 weeks.

Constitutional symptoms. The general condition of the individual in mastoid disease is similar to that in other affections where pus is being absorbed. A coated tongue, pale complexion, poor appetite and weakness, indicate toxemia somewhere in the body. The existence of glycosuria and a high sugar content in the blood, in the presence of persistent otitis media, calls for the utmost precaution. Mastoid pathology may thus be the etiologic factor in the production of diabetes and necessitate early surgery of the mastoid. Occasionally, too, a joint affection, either single or multiple, in the presence of an ear condition with little mastoid evidence, may be the principal clue in the diagnosis of mastoid pathology. I have had several patients of this kind. Hematuria, when acute otitis media exists, might indicate that the mastoid is acting as a focus and that operation on the mastoid is necessary. An unusually slow pulse with an otitis media, but without definite mastoid symptoms, may be the only sign of mastoid disease when there is a developing brain abscess. Just such a patient

was operated upon successfully by Dr. Walter Roberts, at the Graduate Hospital. The abscess was temperosphenoidal in location.

It must be remembered that, in the symptomatology just described, swelling may be, and usually is, associated. A patient having acute mastoid inflammation with pain, tenderness, and fever, should not be operated on immediately. It is better to wait and permit the tissues to build up a natural resistance, and frequently convalescence from the mastoidectomy will be much more rapid. Of course, the "exception to the rule" is the hemorrhagic, fulminating mastoid mentioned before.

In the diagnosis of mastoid disease, definite rules cannot always be given. Every examination should include a thorough history-taking, and careful consideration should be given to the patient's narration of his illness. The information should then be properly evaluated. All the known facts should be correlated with the clinical evidence. Each patient has a separate problem, and demands, and warrants, a searching study.

APPENDICITIS

Harold A. Longsdorf, M.D.,
Mt. Holly, N. J.

Doubtless all physicians had their attention called recently to the subject of appendicitis, given great publicity by our leading insurance companies in the recent past. Hospital groups and leading surgeons have also sought to impress upon other members of the profession, as well as the laity, the increasing number of people dying annually from appendicitis and the important facts connected therewith. As many as 20,000 people in a recent year have lost their lives from this disease. Our hospital, with a 100-bed capacity, has had 800 operative cases in less than 5 years, and I feel that I have justification for offering a few thoughts on this subject.

I am going to devote most of my time to symptoms and diagnosis. Appendicitis is an inflammation of the vermiform process or appendix. The causes are predisposing and exciting. Among the first may be mentioned the peculiarities of the appendix. It is long, narrow, a blind sac, communicating with the intestinal canal. Sometimes it is constricted at its opening. Drainage and blood supply of the appendix are not infrequently interfered with by kinking or coiling of the meso-appendix. Other predisposing causes are influenza, tonsillitis, gastro-enteritis, dysentery and typhoid fever. One attack often predisposes to others.

Exciting causes are intestinal troubles, which spread to the appendix, traumatism, and foreign bodies. Intestinal parasites, stones and seeds are uncommon, but we frequently find concretions of fecal material. Obstruction, which involves the mucous membrane and muscle, interfering with circulation, always causes suppuration. Inflammation of the uterine appendages sometimes causes a secondary appendicitis. Neoplasms, tuberculosis and actinomycosis often involve the appendix. The important factor is infection of the walls with microörganisms, especially colon bacillus. Pyogenic bacteria, especially streptococcus pyogenes, also are found alone or as a mixed infection. As you know, the appendix is normally inhabited by bacteria which become dangerous only when they enter the wall through an abrasion, or as a result of kinks or adhesions.

In discussing the symptoms of appendicitis, I desire to consider them under the 2 headings —acute and chronic—and also call attention especially to symptoms in children. In acute cases, the attack most often presents itself in a previously healthy person. Rather sudden pain often comes on in the region of the umbilicus, later localizing in the right iliac fossa, at or near McBurney's point. This pain may be paroxysmal, but usually later becomes constant and variable in degree. Taken with other symptoms, I would say that pain is the most important sign. It may radiate in different directions, toward the umbilicus, epigastrium, groin, etc. Occasionally it may be located in the left abdomen or left iliac fossa. In the typical case of appendicitis, the pain is most often located at McBurney's point, but it may be, and often is, elsewhere. Pain is increased by direct pressure or pressure on

descending colon, deep abdominal breathing and movements of right leg—especially rapid extension. When the appendix has suppurated or become gangrenous, the pain may temporarily entirely disappear. This is a delusive calm, and may result in dangerous conclusions, as we have all experienced. Coley says that when an acute inflammatory process of the appendix has subsided, leaving a mucous inclusion or scar tissue, there may be no tenderness on pressure at McBurney's point, but that there is tenderness at the right lumbar ganglia and not the left. The ganglia lie about 1½ in. directly on either side of the navel. When both ganglia are tender, it points to pelvic trouble and not the appendix. Deaver has said that suddenly subsiding pain followed by chills, points to gangrene, and exquisite tenderness points to pus. The skin may be very sensitive over the diseased area, for quite a time. Epigastric pain is also significant. It may occur suddenly. It may be constant or intermittent. Nausea and vomiting occur in the majority of cases. These symptoms may occur at the onset or develop later, and are reflex. Vomiting may cease, and recur with the development of peritonitis. Constipation is present in more than 50% of cases. Respiration is not much affected except with peritonitis, when it becomes costal. Temperature and pulse vary. Temperature may be elevated from .5° to 2° in the early cases, depending on the severity. A sudden rise of pulse and temperature usually indicates extension of process to the peritoneum. The tongue is generally coated. Diarrhea may be present but constipation is more common. Rigidity of the right abdominal wall muscles over the appendix is usually present, but I do not feel that too much emphasis should be put upon rigidity—it is a part of the whole picture.

In most cases of appendicitis we have leukocytosis and an increase in the polynuclear cells. However, I think most surgeons agree that in the early stages of acute appendicitis, the blood findings may not be confirmatory, and on that account, in the presence of other clinical symptoms, operation should not be deferred. The blood picture is an expression usually of the virulence of the infection. The leukocytosis is an indicator of resistance of the patient and degree of peritoneal irritation. The higher the blood picture goes, the more severe is the infection, and the prognosis consequently more uncertain.

Hematuria may occur when the appendix is adherent to the bladder or adherent or against the ureter. The disease may come on insidiously and pain and fever be absent. This is true more often in children, the only early signs being perhaps slight colicky pains. Children should be watched and studied carefully. There is a wholly unwarranted impression that appendicitis is not common in young children. Statistics show that a majority of cases of appendicitis in children go on to abscess formation and peritonitis, and consequently many are drainage cases, and the mortality is higher than it should be.

When an abscess or exudate forms about the appendix it may be detected by palpation and sometimes seen. All palpation naturally should be done most carefully. Perforation is often indicated by cessation of pain, to be followed by increase in pulse tension and rate. The fortunate thing in many cases of acute appendicitis is the rapid formation of adhesions, which permits the walling-off of the pus from a perforated appendix, thus localizing the trouble. There are cases of fulminating appendicitis, so named because of the rapidity with which the disease develops. On this account alone we should give all cases the closest attention. Some men do not recognize chronic appendicitis, and have laid so much stress on this idea that it has misled others. This condition may follow an acute attack which had temporarily passed over, or it may be such from the beginning. A common symptom is indigestion, with loss of weight and, sometimes, constipation. Pain of varying degrees, and tenderness of the appendix, are other symptoms. Dr. Lee says x-rays often show fixation and distortion of the appendix after an opaque meal, and if the appendiceal shadow fails to appear, the appendix may be obstructed, obliterated, filled with feces, or obscured by the barium-filled cecum.

Diagnosis of appendicitis is comparatively

easy. The important symptoms, as previously related, are pain, tenderness and rigidity. However, there are many conditions simulating appendicitis, which may lead to mistaken diagnosis. The surgeon should unquestionably, in cases where doubt exists, obtain consent for any other necessary procedure. There may be other conditions present, as complications, for example: intestinal obstruction, perforation, volvulus, and acute infections of the gallbladder, acute pancreatitis, thrombosis or embolism of mesenteric vessels, tubercular peritonitis, inflammatory conditions of the right tube or ovary, extra-uterine pregnancy, or inflammation of Meckel's diverticulum.

There is another group of cases concerned with the kidney or ureter—floating kidney with torsion of the ureters and nephritis. There is still another group in which abdominal section should be unnecessary. Excluding the appendix, a mass in the right iliac region may be due to a neoplasm, as carcinoma of the cecum, ovarian cysts, sarcoma of the ileum, large lymph glands, fecal impaction, intussusception, inflamed, undescended testicle, and so-called phantom tumors. Sometimes one of the most difficult points is to distinguish between appendicitis and stones in the kidney or ureter, because the urinary system is often affected in the appendicitis; x-rays are valuable aids in some of these cases.

Tubercular peritonitis may be mistaken for appendicitis. A differential diagnosis is difficult and often impossible. Careful study of the history in these cases is helpful. Pneumonia or pleurisy is sometimes mistaken for appendicitis, especially in children. I recently saw a case in consultation where the child's family and physician were inclined to believe that appendicitis was present. The child was stout and difficult to examine, but careful examination of the lungs cleared up the doubt, and such an examination, taken with other facts, as the usual temperature findings, should decide the uncertain cases. Disorders of the genito-urinary organs, especially salpingitis, often make for confusion. All surgeons encounter appendicitis with inflammation of the right fallopian tube and ovary. Careful rectal or vaginal examination, while helpful, is not always definite. Salpingitis may occur secondary to inflammation of the appendix. In appendicitis, pain is more violent and more localized. Perhaps a rigid abdomen is a principal differential sign between appendicitis and salpingitis. I have seen movable kidney confused with appendicitis. Here careful palpation will show a movable tumor which slips between the fingers in the case of a kidney.

Infections or catarrhal inflammation of the bile ducts may occasionally simulate appendicitis. Careful examination, presence of jaundice, absence of fever, appearance of the stools, and more severe and continuous pain, and a common pain in the right shoulder region, are important differential points. Perforating gastro-intestinal ulcers may be mistaken for appendicitis, but history—usually sudden, violent pain, often followed by collapse, bloody vomiting or hemorrhage from the bowel—should make diagnosis relatively certain. Extra-uterine pregnancy is recognized by vaginal examination, subjective signs of pregnancy and the fact that there were no inflammatory signs before the rupture. Other less important conditions might possibly be confused with appendicitis, but the foregoing are the usual.

Treatment is operation when the diagnosis is made. This condition, when acute, calls for action, unless there be present a condition that renders operation very dangerous. In this connection I want to remind you that an appendectomy is a major operation. In my somewhat limited experience, and from the testimony of surgeons who daily perform this operation, there are circumstances and conditions that may make it a trying and difficult procedure. Experience, patience, the gentlest handling, and keen judgment, are the things that weigh heavily in the much to be desired end—life, and a reduction of the mortality rate.

I have had a number of interesting cases, of various kinds, but a case of what I believed to be traumatic appendicitis gave me one of my biggest thrills. The patient, a man, was severely bruised over the abdomen and lumbar

region of the spine, in an automobile accident, and almost immediately he developed pain in the abdomen, which under the circumstances was confusing. In a short time he must have had a ruptured appendix, and a rapidly developing peritonitis followed. I operated the next day, immediately upon making diagnosis, but unfortunately the patient died within 72 hours. I reported the case to the Accident Insurance Company as traumatic appendicitis, and after much correspondence and questioning upon the part of the Company's surgeons, the Company disclaimed liability on the grounds that they did not recognize traumatic appendicitis. The case finally came to a hearing before a Judge. He heard lengthy testimony on both sides, and finally asked that each side submit a brief. In preparation of my brief, I consulted the surgical literature of many languages besides the English—French, German, Italian, etc.—and in the end had a most interesting array of authorities supporting my contention. We won a favorable compromise verdict, which I am told was the first case so decided in New Jersey.

In studying the statistics of many hospitals, I find the mortality in cases operated early, where trouble is confined to the appendix, is less than 1%. In cases of localized abscess, the mortality ranges from 5% to 10%[1]; in diffuse peritonitis to 25% and more. Our own statistics on 800 cases are interesting. These 800 include 188 incidental appendectomies, done at the time of some other operation, and in this group there were no deaths due to the appendectomies performed. The following summary shows the number of cases of each type, and number of deaths, with accompanying mortality percentage:

Type of Appendicitis	No. of Cases	Deaths	% Mortality
Chronic	141	1	.709
Incidental	188	0	.0
Acute suppurative	356	3	.842
Acute gangrencus	64	3	4.68
Appendiceal abscess	28	1	3.57
Spreading peritonitis (appendix not removed)	23	6	26.
Totals	800	14	1.75

I have performed approximately 150 appendectomies in this group of cases, which represents cases from the combined practices of myself and Dr. G. E. McDonnel, together with a few general surgical service cases given me by Dr. Lee and Dr. Summey. In practically all instances, operation was performed immediately after diagnosis, and the majority within 24 hours after attack. There was one death, that a case of ruptured gangrenous appendicitis, with peritonitis, and further complicated by alcoholism with delirium tremens. I call your attention to the foregoing principally to emphasize the very low mortality rate in what might be termed largely a selected group of cases. You can readily see the possibility for a very low mortality rate, through early diagnosis and prompt removal to a hospital.

In conclusion, may I emphasize the following points: Give patients with acute abdominal pain careful consideration and see them sufficiently often. If at all suspicious of a surgical condition, withhold salts, castor oil or laxatives, and help disseminate this information. Be especially on guard when you encounter a case of persistent abdominal pain, not clearing up in 10 or 12 hours. Make more rectal examinations. Remember that probably 25% of all acute appendicitis cases unoperated die. Remind your patients that there is little to fear from anesthesia, and that there is as much consideration given to this as there is to the actual operation.

RADIATION IN CANCER

Douglas Quick, M.B., F.A.C.S.,
New York, N. Y.

During the past few years, radiation has come to be accepted as of value in cancer therapy. The accumulated experience with radium and x-rays gives us today a considerable amount of rather accurate information on which to base the usage of these agents. At least, the empiricism of 10 or 15 years ago has been replaced by methods of reasonable accuracy founded on the observation and experience of many workers. Such detailed information has not been widely disseminated. The average physician, especially in general

practice, sees relatively few cases of cancer per year. Consequently, there is a certain degree of misunderstanding as to the place of radiation (radium and x-rays) in the cancer field.

Irradiation therapy is frequently regarded as a simple procedure, requiring little equipment and little time on the part of the patient for carrying it out. Fortunately, we are far beyond the period where a bit of radium is strapped on for a few hours, or an exposure of x-rays given, and the patient sent along to await results. All too frequently, radiation is thought of in connection with advanced cancer only. It is true that irradiation therapy has been of great value as a palliative in the advanced stages of the disease. If it has accomplished nothing more, its use remains justified on this score alone. Considering all types of cancer, the ultimate curability is between 20% and 30%. The care, therefore, of the remaining 70% plus, in a palliative way, frequently prolonging life in comfort and usefulness for several years, is of vital importance. The value of radiation does not stop with this group, however. Through the influence of the physical agents, the curability rate is gradually being increased. The severity of operative procedures, with their resultant shock and mortality, is being gradually lessened. The extremely mutilating operative procedures are decreasing. There is no longer necessity for performing eleventh hour operations on advanced cases for the sake of "doing something".

This is not meant to imply that operative surgery is being superseded by use of physical agents. Treatment of cancer is largely a surgical problem. The care of a few groups has come to be a radiation, rather than an operative surgical, procedure. On the other hand, certain new operative procedures have come into the picture, by reason of the use of the physical agents. Through combined use of operative measures and radiation, a substantial portion of the less desirable side of operative surgery in cancer is being eliminated. The actual amount of operative surgery is probably about the same. The severity of the procedures is decidedly reduced and ultimate results improved. In other words, through coördination of modern irradiation therapy and surgery, a new type of "cancer surgery" is being well established.

Unfortunately, the impression holds in many quarters that radiation and surgery are competitive measures. It is true that in the vast group of allied diseases coming under the general heading of "cancer", a few may be cared for equally well by surgery or radiation. The choice of procedure becomes a matter of election. Altogether, however, these 2 agents or methods are strictly complementary. They are not competitive. They represent the only means at our disposal today for treatment of cancer. Progress is to be made through a closer coördination rather than on a competitive basis.

A good deal of confusion rests upon the relative positions of radium and x-rays in irradiation therapy. Actually, there is little overlapping of the 2 fields. X-rays are for external application only. They lend themselves to use over large areas of body surfaces. Economically, there is no practical limit to the quantity of x-rays available. Fortunately for progress in the work, the quality of therapeutic x-radiation is being steadily improved through the efforts of the physicist and the electrical engineer. Radium for external application is limited in a practical way to small areas. Its chief use is within the body cavities, and especially for direct implantation within tissues in the form of the element or filtered radium emanation (radon). In this latter form it has its greatest usefulness in direct conjunction with operative surgical procedures.

The use of large amounts of radium for external application is of interest in the cancer institutes, by way of clinical experiment. It serves as a comparative guide to x-ray therapy, rather than being a competitive agent. From a practical standpoint, use of radium in this manner is economically unsound for routine clinical work. Well-done x-ray therapy is preferable for external irradiation in every-day practice.

Another guide of tremendous value in selection of treatment methods, and one which is apt to be confusing, is that based on the

histologic study of tumor tissue. The histologic "grading" of tumors has come to be popular, and the relative radiosensitivity of a tumor is apt to be regarded as in direct parallel with the grade in which the tumor may be placed. An appraisal of the probable degree of radiosensitivity is dependent on many factors beyond the grade of the tumor. Grading is simply an indexing of the given tumor on the basis of its relative degree of cellular differentiation. It is dependent to some extent on the personal equation of the individual tumor pathologist. No 2 tumor pathologists can regularly place exactly the same interpretation on every tumor. It is true, in a general way, that the more anaplastic tumor responds more promptly and completely to a given amount of radiation than does the more fully differentiated tumor. The parallel, therefore, is obviously more nearly complete within the individual tumor groups than between tumors of different groups. There is no comparison in relative radiosensitivity between a grade I epidermoid carcinoma of the cervix uteri and a grade I (or grade II or III) adenocarcinoma of the fundus uteri. Even within individual groups, the degree of cellular differentiation, on which grading is based, is not a direct guide to relative radiosensitivity. The very delicate and free capillary blood supply of the more fully differentiated tumor may alone render it more radiosensitive than the tumor of lesser differentiation with a less sensitive blood-vascular apparatus. The anatomic location alone has a bearing on radiosensitivity. For instance, an epidermoid carcinoma, of whatever grade, at the base of the tongue, is relatively more radiosensitive than an epidermoid carcinoma of comparable grade in the tongue anterior to the base of the anterior tonsillar pillar. The normal histology of the portion of the organ involved is undoubtedly one of the many factors entering into an explanation of such a peculiar phenomenon as this.

The degree of advancement of a growth has its bearing on the relative radiosensitivity, and secondary deposits are more resistant than the primary growth. Recurrences are likewise more resistant to a given amount of radiation than is the primary. The extent of ulceration and secondary infection in a tumor does not appreciably alter the tumor grade, but it does reduce tremendously its response to irradiation.

As a tumor progresses in its dissemination throughout the body, the response to irradiation becomes progressively less, and out of proportion to the local response of any one given area. A general constitutional influence is evident. The age and degree of relative anemia have a distinct influence on response to irradiation, even though the histologic structure of the tumor remains unaltered. The same is true of complicating general medical conditions.

To recapitulate, therefore, the relative radiosensitivity of a tumor, within a given tumor group, is dependent on many factors beyond the simple histologic grade of the tumor. There is no comparison in radiosensitivity, *histologically*, between the different major groups of tumors. This is a matter determined on the basis of clinical experience.

Within the various groups, however, grading and appraisal of relative radiosensitivity, taking note of all recognizable factors, is of great practical importance. The more radiosensitive tumors, speaking generally, call for a greater dependence, in selection of the combination of therapy measures, on physical agents. The more resistant growths indicate a leaning more heavily toward operative surgery. In extremely anaplastic growths, surgery, except to facilitate irradiation, is contraindicated. It is true of fully differentiated growths (grade I) of whatever group, that a result once obtained is much more likely to be permanent because of the lesser chance of distant and widespread dissemination.

Reference has just been made to the degree of greater dependence toward surgery or irradiation based on appraisal of relative radiosensitivity. This does not mean the employment of surgery alone or irradiation alone. There are few cases of cancer in which all 3 agents—surgery, radium and x-rays—do not play a part to advantage at some stage in the care of the case. It is a matter of deciding the relative position of each in the individual

case. Once this has been determined, the sequence of procedures and methods of irradiation best adapted to the case is to be decided.

Fortunately, the empiricism of a few years back has been replaced, in irradiation therapy, by methods of reasonable accuracy. Dosage is better understood, and the most advantageous manner of apportioning dosage is well in hand. In certain groups, notably in carcinoma of the head and neck, the minimum limits of dosage necessary for the varying degrees of differentiation are fairly well understood. Fully differentiated epidermoid carcinoma of the mouth, for instance, requires the equivalent of at least 10 skin-erythemas in intensity of irradiation, to completely control growth. It is obvious that this cannot be delivered entirely by external irradiation; hence, implantation of radium in some form must be resorted to. On the other hand, anaplastic growths in the same location are prone to disappear completely with an intensity of 3-5 skin-erythemas. This may, with safety to the skin, be given by external irradiation (preferably by x-rays) if proper technical methods are observed.

As to sequence of the various measures, one can only generalize. Ordinarily, it is best to employ external irradiation first; follow this by implantation if such be needed; and finish by operative surgical measures if they be for removal of tissue. In the event that surgical exposure is necessary for the radium or radon implantation, the 2 procedures become each a part of the one operation.

Absolute accuracy is essential if best results are to be obtained through use of the physical agents. This is true of external applications of radium or x-rays, and all the more so of radium needles or radon implantations. The latter are strictly surgical procedures, and as such, are dependent for success on the same character of surgical accuracy as is the most delicate sharp dissection. The accuracy applies not only to technical procedure but to the careful calculation of radiation intensity along the lines of dosage intensity for varying types of growth, previously referred to.

The entire problem of present-day cancer therapy, if carried out to best advantage, in the light of information now available, extends well beyond the grasp of a single individual. It is a problem embracing the services of a physicist competent in the physics of radiation, an expert tumor-pathologist, and a surgeon well versed in the fundamentals and details of irradiation therapy. If the latter is not available, the close coöperation of a radiation-minded surgeon and a medical radiologist is essential to success.

The fact should never be lost sight of that the average cancer patient is also an individual in the degenerative period of life. He or she is subject to the same general diseases of the period as are persons free from cancer. While the cancer clinician is caring for the malignant disease, there is ample need for the expert services of the internist or family physician. Active supporting medical measures are necessary to the successful carrying through of the average case.

In discussions on cancer therapy, attention is usually focused on measures aimed at "cure". Since the majority of cases are ultimately incurable, great care should be given in the preliminary appraisal to determine whether or not the case offers a reasonable hope for cure. If there is a reasonable chance, then every effort ought to be exerted in that direction and to the exclusion of all other considerations. If such chances are remote, the procedures planned should give consideration to the comfort of the patient from day to day and week to week. A great deal of needless suffering may thereby be avoided. Prolongation of life alone, without reasonable comfort in the interim, is of doubtful value except perhaps in a few instances.

Palliative measures should be of less severity and less intensity than measures aimed at cure. It is the opinion of the writer that a good many simple operative procedures for palliative purposes only, are too frequently frowned upon by general surgeons.

The coördination or combination of surgery and irradiation may to advantage be considered from various angles. The popular conception of this centers around pre- and post-operative irradiation. There are numerous

instances where postoperative therapy is the only alternative—the operation may be necessary to establish the diagnosis in cases of difficult clinical differentiation. However, in operable cases with little doubt as to the clinical diagnosis, preoperative irradiation to the maximum of skin tolerance is, in the opinion of the writer, the method of choice. It permits of the maximum of favorable reaction on the part of all tissues concerned, both of tumor and tumor bed. Once the blood supply has been interfered with and post-surgical inflammatory congestion appears, the most advantageous reaction cannot be expected. The scar will not permit the same radiation intensity. It is a comfort extending beyond the point of mere theory to operate on a regressing tumor, rather than on one in which dislodgment of a tumor embolus during the manipulation may mean a distant metastatic deposit. There is no loss through waiting for the intensity of skin reaction to subside before operating. It assures prompt healing and permits carrying on the operative procedure during the safest period—the period of beginning fibrosis.

One of the largest fields for irradiation therapy is that carried out at the time of the surgical operation by some form of implantation, and under varying conditions. Personal experience is strongly in favor of filtered radon implants for this type of work. They lend much greater facility and are attended by less technical risk. Many cases regarded as operable are approached surgically only to find as the operation advances that a clean wide removal is impossible—a portion of the tumor or a suspicious area must be left. Unless rádon is available at the moment, the best chance for efficient and accurate irradiation, often with chance for complete control, is lost. There are many instances, of which certain of the metastatic cervical nodes furnish best examples, where surgical exposure for radon implantation is attended by much greater accuracy and safety than would be the case were the implantation attempted through skin puncture. Such surgical exposures are simple procedures, usually done under local anesthesia. Neck exposure for ligation of vessels often affords an excellent opportunity for implantation as well. Certain primary growths; difficult of satisfactory technical approach for implantation, may likewise be exposed directly. Intrinsic carcinoma of the larynx which has extended below the cord level is a good example. It frequently occurs that surgical access and drainage are both necessary, even though the direct treatment of the malignant growth is best handled by irradiation. Such circumstances are usually encountered in dealing with cancer of the superior maxillary antrum and the accessory sinuses.

Secondary invasion of bone by new growth is very resistant to irradiation. Not only is the tumor bed unfavorable, but it is essentially an area of osteomyelitis as well as tumor growth. Destruction of growth by irradiation, and subsequent surgical removal of the bone, gives better results than a surgical resection alone. This picture is encountered most frequently perhaps in growths of the soft parts adjacent to the lower jaw. Limited surgical removal can often be done through the mouth, and not only is it a safer procedure, but one attended by a lesser deformity as well.

Ulcerating tumor growth is always attended by varying degrees of sepsis. This not only interferes with a normal reaction to irradiation but it increases pain, deteriorates the patient's general condition, and prolongs unnecessarily the period of healing. Under such conditions, it is at times advantageous to use the ulcerating tumor mass as a "holder" for radon implants, until such time as sufficient irradiation has been delivered, after which the entire area is removed by one of the cautery methods. This permits proper irradiation, and at the same time permits a surgical cleaning up, with consequent lessening of pain, relief from sepsis, and hastening of the healing period.

One of the most complete examples of the combined use of surgery, radium, and x-rays, is to be found in our method of dealing with intra-oral epidermoid carcinoma. All patients accepted for aggressive treatment receive, first, x-radiation through both sides of the neck, covering the lymph-node bearing areas,

and with the field extended to take in the primary growth as well. Following this, and in all but the extremely anaplastic growths, the primary tumor is implanted with radon. Routine block dissections of the neck are not done. If there are no palpable nodes in the neck, there is no further neck treatment. The patients are kept under routine observation. If a node appears, one of two procedures is followed. If the growth be of adult type—fully differentiated, patient in good condition, primary growth controlled or under control, and node in question encapsulated—a complete unilateral dissection is done. Under all other circumstances, a limited surgical exposure under local anesthesia for purposes of direct radon implantation is resorted to. If the primary growth is not controlled, there is no object in doing a dissection of 3 or 4 hours' duration. Elderly patients, and those in poor general condition, are not equal to it. Few cases where the disease has perforated the capsule of the node are cured by the most radical dissection. The undifferentiated growths do better by irradiation alone than by any type of removal.

This illustrates the fact that operability limits are considerably narrowed under the influence of associated irradiation in dealing with cancer of the mouth and neck.

The same is true, but not to the same degree, in breast cancer. The complete operation, plus pre- or post-operative irradiation is limited to the more favorable group. In those with extensive and high axillary node involvement, irradiation is undoubtedly preferable to the unhappy results of attempted radical mastectomy.

There are a few major groups of cancer in which surgery has been largely replaced by radiation. Growths of the skin come chiefly within this class. Cancer of the cervix uteri is entirely a problem for irradiation. On the other hand, cancer of the fundus uteri, a disease differing both histologically and anatomically from that of the cervix, remains in the field of operative surgery, with or without preliminary irradiation, depending on the attitude of the individual operator.

WHAT DO PATIENTS EXPECT FROM PHYSICIANS?

Thayer A. Smith, M.D.,
Short Hills, N. J.

As I review the current literature in our medical magazines, and the titles of papers at our medical association meetings, I am impressed with the fact that the subjects dealt with are almost exclusively purely scientific in character, and only on rare occasions is anything presented on that very important phase of the practice of medicine—the relation of doctor to patient. As a general practitioner in a small suburban town, I may be in a strategic position to submit a few thoughts on what a physician has to give to his patients, and what the patients expect from their physicians. There will probably be nothing new or illuminating in this paper, and yet I feel that there is value in occasionally taking an inventory of our stock, and ascertaining whether we are using our full equipment to the best advantage, and not underrating the value of some of our most potent weapons.

The most obvious weapon of any professional man is, of course, a knowledge of his subject, and if medicine, or the practice of medicine, were purely a science and not an art, it would indeed be the principal weapon. We spend 4 years of a hard grind in medical school and 2 or 3 more years in hospital, acquiring this knowledge, and then, in various ways, are working at it all our lives; and it is no wonder that we start out, at least, feeling that this is by far the most important part of our equipment. And, in a way, it is, for it is or should be the *sine qua non* of the medical practitioner, and particularly, of course, of the specialist. But it is merely the technic of medical art, comparable in a way to the technic of the concert pianist. The music lover does not go to the concert hall to observe the facility with which the pianist plays notes. If he were unable to play notes, he would fail in the expression of his art. But in the mind of the music critic, the perfect technic is as-

sumed, and the pianist's expression of his art begins from this point.

From the point of view of the laity, there seem to be 2 views with regard to a physician's knowledge of his subject. Fortunately for us, or perhaps unfortunately in some cases, many laymen assume that every doctor has, or ought to have, tucked away in his brain every detail ever known that is pertinent to the profession. What a disappointment they sometimes get when their physician sheepishly acknowledges that he has never heard of some patent medicine one of their friends has recommended, or can't remember the exact incubation period of a contagious disease, or the number of teeth the baby should have at the end of the first year, or is unable to tell them off-hand about syringomyelia, the unusual disease from which Cousin George was said to be suffering. Yet even such disappointing deficiencies as these will not disturb their general assumption that if a man is a doctor—well! he *must know*—almost pathetic in its *naiveté*. At the other end of the scale, and perhaps nearer to facts as they are, is the smaller group who think that no physician really knows much of anything. They have some obscure and obstinate ailment and have made the rounds of New York, Johns Hopkins and the Mayo Clinic, with a different diagnosis at each place, and no improvement, and quite justifiably become a skeptical with regard to the erudition of the medical profession. Now, the point I want to make is that in neither of these 2 situations will a physician be chosen on the basis of his professional knowledge. In other words, the knowledge is assumed or despaired of, and other qualifications appear to have greater importance as a basis for selecting the man who can give most help. How many of your patients know where you received your medical education, or how thorough and complete that education has been, unless you have been strong on blowing your own horn or having one of your friends blow it for you? It is true that most of our patients know in a general way at what hospital we work, and, if the hospital enjoys a good reputation, the prestige of the physician is thereby increased; but beyond this, few of our clients, certainly in a suburban or country practice, have any idea of how well or how badly trained we may have been, nor do they seem interested in finding out. A man may even advertise himself as a specialist, and as a rule the advertisement is accepted at its face value even by intelligent people, and no attempt made to ascertain what justification he can put forward for his title. I am in a better position than most of you to hear lay comments on individual physicians.

Practically the only occasion when I have heard a physician branded as unfit in professional knowledge is when he has made some error in diagnosis and has lost his patient to another man who was able to correct him. Even under such circumstances, the physician's cliéntèle is, as a rule, not much disturbed, so much more weight do patients put on other things besides professional knowledge. As one of the older practitioners in my vicinity expressed it to me: "Your successes will help you greatly and your mistakes won't do you much harm." The comments that I hear which indicate on what basis a physician is chosen or retained run more like these: "I used to have so-and-so, but he talked so loud, he got on my nerves." "Dr. ——— is too much of an old woman, I couldn't stick him." "Dr. ——— is very good if you are very ill, but you have to be practically dying before he will take any interest in you." "We had Dr. So-and-so for mother for a time, but instead of giving us any hope of improvement, he kept telling us, with a long face, how lucky we were that she was still with us." "Dr. ——— (a young man) is nice, but if I asked him to come and see Mr. So-and-so, I am afraid he would be scared to death, Mr. ——— is so ill." "All Dr. ——— cares about is collecting his fee." "Dr. ——— has just 2 kinds of pills and gives one or both to everybody." About a surgeon: "I don't dare go to him because he wants to operate right off on everything." About an obstetrician: "I wouldn't have Dr. ———. My sister had him and went to the hospital the day before her baby came, and the intern had to deliver her, as they couldn't get hold of Dr. ——— at the critical time." About a pediatrician: "I took my child to Dr. ——— for

a time but he used to tease her every time she went. I don't think he knows children well." All these are actual quotations of comments that I have personally heard, and indicate some of the directions along which we, as physicians, may give help, and are expected to give help to our patients, other than by means of our professional knowledge.

Our early training, and, to a certain extent, our subsequent institutional work, tend to make us overlook the importance of our extra-technical armament. We emerge from medical school with our minds centered upon our ability to make a diagnosis. How many a young M.D. chooses a surgical internship because he feels that no other field offers an opportunity to really do anything for the patient. Hospital training gives us a little more idea of therapeutics and the personality of the patient, and yet here, as in subsequent out-patient department work and ward work, we lean on the hospital and allow it to give the patient what we would have to give ourselves to our private patients. That is to say, the patient approaches the hospital or clinic, not as a rule because he has confidence in you or any other particular physician, but because he has confidence in the Presbyterian Hospital or the Cornell Clinic or whatever the institution may be. As long as this confidence lasts, we can get away with a great deal of slipshod and incomplete attention to the patient, and still wear a halo over our heads because we are representatives of that particular institution. Often we feel that haste is a necessity on account of having to see a certain number of patients in a limited time. But, as long as we feel that we are merely a part of the machinery that contributes technical skill, we are getting into bad habits of using only a portion of our equipment for helping the sick, and feeling that our job is done with only this partial contribution. In out-patient work particularly, it seems to me sometimes as though medicine were not being practiced as an art, but more as a business where the commodity of technical skill was being sold over the counter. The patient goes through the mill of the admission routine, is checked and re-checked, and given a ticket. The doctor takes a routine history, often too laconic on the patient's part from actual fear of presuming on the busy doctor's time, and often greatly exaggerated from fear that otherwise no impression will be made of the seriousness of the case. A routine physical is then done, and if any excuse can be found for shipping the patient to another department for examination by other specialists, he is told to go there for further study. Or, if the doctor is pressed for time or is feeling mentally lazy, he may refer him for a blood count or Wassermann or some other laboratory procedure before he has really thought over the case, rationalizing to himself by arguing that he isn't being thorough without these laboratory data, whereas in reality he is thus disposing of the case without being thorough in thinking. The patient returns the next week and may see the same physician or perhaps some other physician, and if he hasn't benefited by formula No. 329 he is given No. 330 to try for the next week. Thus the patient goes through a mechanical routine, with implicit faith that he is getting the best possible care because he is at such-and-such a hospital, and often not getting half of what the physician *might* give him.

True, many ailments are adequately treated by this over-the-counter medicine, but others are not, and at all events it generates undesirable habits in the physician which should be guarded against. I recall one occasion when I was visiting in a certain well-known clinic in the department of general medicine. The patient was a high-strung middle-aged woman who presented some vague stomach symptoms. The physician was a very able man who has done brilliant research work. The routine was gone through, and as he dismissed the patient, the physician said: "Now you take this medicine after each meal and don't worry—above all things *don't worry*." He had made a fairly thorough physical, and had of course felt that worry was playing the major part in her difficulties, but had made no attempt to help her on that score except for the bare recommendation. This woman had already been to several other clinics, and I have no doubt after trying out her medicine at this clinic, and receiving no benefit, went on to the next. Please

do not take this as an indictment of the work that is being done in the various clinics, for which I have a great respect. I only want to point out the ease with which those who are working under the shelter of the hospital may fall into habits of giving only a portion of what they are capable of giving to their patients. As. Dr. S. Weir Mitchell once said: "However far medicine may develop as a science, the successful treatment of the sick will always be an art."

The whole purpose of this paper is to lay stress upon the importance of the less technical psychologic aspects of the doctor-patient relationship, of which everyone who is treating the sick, whether he be general practitioner or surgeon or specialist, should be keenly aware. I have tried to bring out thus far that, from the patient's point of view, the physician's technical ability may not be of paramount importance. What then, has a doctor to give to his patients aside from his professional knowledge and skill? The term usually used is *personality*, but this is too general and indefinite and I would prefer to analyze this further. The patient wants above all things to have *confidence* in his physician. What attitude or attributes of the physician inspire this confidence? Perhaps decision should be mentioned first. A patient comes to the doctor wanting to know what the nature of his ailment is, how long it will last, and what he can do for it. Many laymen, even in the so-called intelligent class, fail to realize that these questions often require a period of observation and perhaps even then cannot be given a definite answer. Our impulse is to be honest to a fault and present the patient with the whole picture of what is going on in our own minds with regard to these points. But this may necessarily involve an attitude of indecision, which, in turn, is upsetting to the confidence of the patient. We may feel that the patient should be impressed by a dissertation on the several things that the ailment might be, with all the respective evidence for each diagnosis, but actually they are more impressed if we give them a decisive and definite verdict. Dr. David Bovain, with whom I was associated when I first started practicing in New York, used to say: "Don't hedge. It is much better to commit yourself and admit later on, if necessary, that you were mistaken, than to try to protect yourself by being too guarded in diagnosis." And I have had opportunity since then to observe that this advice was sound. I am sure that I have lost patients myself by failing to follow it, and I have heard patients on more than one occasion criticize an able physician for not seeming to be able to tell just what the trouble was, while a much inferior man comes along with cocksureness and takes over the patient and the family's confidence.

With regard to prognosis, of course, the public is better educated to realize that a doctor must often be rather indefinite. Yet here again the physician can do much by giving his prognosis with the patient's needs in mind rather than his own protection. It is a help to any sufferer to be able to look forward to a definite time when he will be free from suffering, even if this period is longer than he had at first anticipated. We dislike to pin ourselves down to any definite time, because in so doing we frequently turn out to be wrong. Also we like to give ourselves a good margin, for it is disturbing to our pride when we have predicted 2 weeks as the duration of the illness, to have the third and fourth week pass with the patient still incapacitated. Yet I feel sure we are doing more for the mental outlook of the patient in being definite and optimistic, even if we are risking our reputation for prognostic acumen.

Thoroughness is an important element in inspiring confidence in patients, though it is easy to get out of the habit of thoroughness when we are pressed for time. I have been much impressed by what must be a very casual survey of the patient's history and physical condition on the part of many physicians, for many times a patient has said, after I have put him through the ordinary history and physical that we all have been trained to do in the hospitals, "Doctor, I have never had an examination like that before," and their satisfaction is very evident. On the other hand, the laity are getting more and more educated in the matter of what a thorough examination

should cover, and not a few of them have learned to expect thoroughness, so that, if we fall short, even if the details we have omitted may actually be irrelevant, we lose confidence by their omission. I think this is particularly true of urinalysis. Urinalysis is the one laboratory examination which has become part of the routine of all insurance examinations, largely because of the relatively slight inconvenience to the patient. This examination has come to have a significance in the minds of the laity, even greater than is often warranted by the clinical picture; so that, even if there may be no particular indication for urinalysis, a failure to make this examination may brand us as lacking in thoroughness.

It is easy for specialists to drop into a habit of lack of thoroughness, especially if they are successful enough to be continuously pressed for time. They are conscious of the strategic position they are in in relation to the patient, inasmuch as the patient attributes to them in advance superior ability in passing on the ailment. And too often they see the whole as related to the part, instead of the part as part of the whole. In other words, they try to bring the whole condition of the patient into line with the difficulty that comes under their specialty, and are often not warranted in doing so.

I have under my care a neurotic man of 55, who has had symptoms referable to his heart, but repeated examinations by various physicians have failed to reveal any objective evidence of heart trouble except slightly low voltage in the QRS deflections in his electrocardiograms. One of our best senior general medical men in New York was a friend of his family, and I urged him to go let Dr. ——— look him over. He finally did, and received a thorough examination with perhaps 45 minutes altogether in the interview. He came home enthusiastic and talked about what a fine man Dr. ——— was, and what a wonderful examination he gave. About a week later, the industrial organization with which he is connected insisted upon his seeing another man whom they use for heart consultations, and who is one of the high ranking men in New York in that line, and an author of books on heart subjects. This physician asked him a few pointed questions, listened to his heart, and sent him in to the next room for an electrocardiogram. The whole interview lasted perhaps 15 or 20 minutes. The patient's reaction was that of being rushed through the mill and his impression disagreeable. "What can he tell about me with such a hurried examination as that? He gets his $50 from the Company and gives nothing but a snap diagnosis"—was his comment. Certainly this is another instance of making the practice of medicine an over-the-counter business, and an instance in which a different attitude and just a few extra minutes of time might well have increased the value of the visit to the patient a hundred fold.

Isn't it really a lack of thoroughness in handling the patient which has brought about the wholesale enucleation of tonsils in recent years? How easy it is, when one is in doubt as to what therapy to offer, to recommend tonsillectomy if the tonsils look at all questionable. In a private school in which I act as advisory physician, there are approximtely 110 pupils above kindergarten age, and only 10 pairs of tonsils among them—seemingly an absurd percentage for a normal robust group. In my opinion, there are few instances in which we are justified in recommending tonsillectomy without a careful and painstaking study of the patient over a considerable period of time, and in making our decision we should ask ourselves: *"Will* tonsillectomy benefit the patient?" rather than: *"May* it have beneficial effects?"

Another tendency which we slip into easily as a result of our hospital training is that of over-treating. The house physician or surgeon is naturally anxious that his attending shall not find any omission on his part in the care of the patient, with the result that the new patient is often bombarded with a textbook full of treatments and remedies before he is fairly settled in his bed. This carries over somewhat into private practice later on, particularly with seriously ill patients. The healthy person or the patient who is only slightly ill can stand a multiplicity of manipulation and medication without any very disastrous results, but when

a patient is seriously ill, too much treatment may be literally too much of a good thing. When the balance is delicate between improvement and losing ground, a potent drug or even a comparatively innocuous drug may be a dangerous weapon, as our knowledge of pharmacology is inadequate to cover the delicate effects and by-effects that a drug may have on individuals as contrasted to human beings as a whole. The routine use of digitalis in pneumonia was enthusiastically advocated for a time, but received a set-back when statistics on a large series of cases were collected. I recall seeing in one of our major hospitals a woman who came in with a high fever and bad throat. She had no membrane visible, but her family physician had had a culture and found some diphtheria-like organisms in her throat and had given her a fair-sized dose of antitoxin. On the night of admission to hospital, a throat smear was taken, diphtheria-like organisms again found, and a still larger dose of antitoxin was administered. A few hours later she developed what appeared to be a very severe anaphylactic reaction and almost died. She did, however, recover, but shortly after developed pneumonia, then a lung abscess, and finally died. I couldn't help wondering how that woman might have come out if she had never had the second dose of antitoxin. Sometimes I can't help feeling that the physician with the best judgment is the one who knows what not to do for the patient, rather than vice versa. Of course, this applies to surgeons even more than to medical men. Our desire to do something concrete for the patient may run away with us, and make us forget that natural recuperative forces may be hindered rather than helped by too much interference.

Another attitude which a patient wants, and which he has a right to expect from his physician, is optimism, and by this I mean a positive attitude rather than a mere avoidance of pessimism. The only way this can be transmitted to the patient is by the physician having a genuine subjective attitude of optimism himself, as the sick patient is much too acute and sensitized an observer to gather his impressions of the physician's attitude from what the physician says alone. How often have we all heard the patient relate, after a crisis is over, how cold shivers went down his back as he scrutinized the serious faces of the consulting physicians, strained his ears to overhear a word, and read into his fate the very inflection of voice with which the verdict was pronounced. After all, medicine is an inexact science, and the wisest and seemingly most certain prognosis is not infrequently upset, so we have ample justification for a habit of optimism, even when dealing with desperate cases.

The moot question arises here as to how much a patient should be told when he is found to be suffering from what we regard as an incurable disease. It is easy for us in the pink of health to say with bravado that we would much rather know it if we were in such a situation ourselves, but, after all, the sick person's outlook and emotional status are usually abnormal and we should bear this in mind when we decide what to tell. My own feeling is that they should rarely, if ever, be told the whole truth in so many words. Many of them know it anyway, without ever being told, and in such cases saying anything would be bringing up unnecessarily a painful subject. Others deliberately blot the possibility out of their conscious mind, and cling to a straw of hope, and we have no right to destroy this hope, for we don't know enough to predict with 100% accuracy.

A year ago a 55 year old man came under my care with vague stomach symptoms and pronounced symptoms of exhaustion and general weakness. Some 10 years previously, he had had a period of profound nervous exhaustion, with a number of weeks in bed, and symptoms very similar to those of the present illness. At that time he had received various forms of endocrine therapy, and had been told his ductless glands were out of balance. With the persistence of symptoms, and following some abnormal x-ray findings, he was operated upon at Christmas time, and a large mass appeared in the anterior wall of the stomach which the surgeon considered inoperable carcinoma, and he was promptly sewn up without doing anything. The patient was a highly intelligent man—a retired lawyer—and a conference between family and physicians was held over what to tell him. As the mass resembled

a chronic indurated ulcer and, in fact, may have started as such, it was decided to tell him that an ulcer was found and it was considered wiser to treat this by medical methods than to cut it out. This verdict he accepted. He improved after operation so much that he was up and out and putting on weight, and the family began to believe we had been mistaken, and we began to have doubts ourselves. In the early summer, however, he suddenly began to go downhill, and died within 3 weeks. Yet not over 10 days before he died, he remarked to me: "This couldn't be cancer, because if it were, I would have been dead long ago." He saw death coming, but apparently believed to the end that his trouble was some disorder of the endocrines that no one had discovered. In this case, I felt that the optimistic attitude had been more than amply justified, and the family were especially appreciative on this particular point. Both patient and family had almost completely escaped what might have been a protracted period of mental suffering.

Finally, I want to refer to an attitude on the part of the physician which requires even more injection of his personality into the situation than does optimism. This is what I will call, for want of better terms, a state of personal rapport with the patient. This is impossible without an active subjective interest in the patient as a personality, aside from his disease. Many an old-time physician has been referred to as having scant knowledge of science, but abounding in knowledge of human nature. From our point of view he may have practiced bad medicine, and yet given far more satisfaction to his patients than many of us are giving. He understood them as human beings, and there is probably no other one thing that inspires as much confidence as a sense of being understood. We have far less excuse in these times for failing to understand our patients, for we have at our disposal an enormous amount of material on human reactions and behavior that comparatively recent studies in psychology, psychoanlysis, and psychiatry have brought out. It behooves us all, who have the intimate human relation of doctor-patient to deal with, to become fairly familiar with this material, and to use it. A psychologic understanding of the patient, however, though a tremendous help to the physician, is a means to an end and not the end itself in establishing personal rapport. A physician may intellectually completely grasp the ins-and-outs of the patient's mental processes, and yet leave him cold—just one of his cases. The patient wants the feeling that the physician is interested in his individual needs and is really anxious to help him. Naturally we all want to help our patients, but this desire must be a sincere sympathy—a true giving of ourselves—and not a desire to help merely for the purpose of enhancing our reputation or increasing our practice or giving ourselves the self-satisfaction of a difficult technical job well done. In such instances the patient may reap and enjoy the fruits of our self-centered efforts, but he senses accurately—and particularly the seriously ill patient—that he is just case number so-and-so, and is cheated out of a great deal that the physician has it in his power to give. A Philadelphia physician, who specializes in gastro-enterologic work, once remarked to me: "These poor devils go the rounds of the specialists, who study them by x-rays and drain their bile ducts and send them into the hospital for chemical examinations and then give them a diet and some medicine, and they get no better; then they come to me and I give them a little sympathy and they promptly respond." I know a high-standing specialist, of delightful personality, who falls so short of what he might be giving his patients by employing the wrong type of office nurse. She is highly efficient and saves him much time, but with the patients she is abrupt in manner, inconsiderate, and utterly lacking in sympathy, herding them in and out like so many sheep. Even the physician, with his excellent personal approach, cannot overcome the sense of being just one of the rank and file which they get in the outer office.

Any routine method of handling or treating patients, while desirable perhaps in some respects, endangers this feeling of being individually understood, as in the case I quoted, of my patient who was sent by his industrial concern to see their heart consultant. I recently asked a woman from another section of

the country what gave her confidence in a physician. She replied she wanted her physician to come and outline every detail of the management of the case—to put her to bed for a time, supply nursing care, give her a diet and medicine, and come to see her every day; this in contrast to the physician who would make light of her symptoms and tell her somewhat vaguely to take a little cathartic, and she would be all right soon. For her physician to give her all she needed, an understanding of her as an individual would be absolutely necessary, for his next patient might be better satisfied with the comparatively casual handling which she deplored.

A phrase which doctors use too often, and which really discredits them instead of the patient, is: "There isn't much you can do for so-and-so, she enjoys ill health." This may be a semi-humorous crack, but, in the first place, it isn't true, for nobody really enjoys ill health even though they may enjoy the attention ill health brings; and in the second place, it implies an attitude on the physician's part that the patient doesn't want to get well and is failing to coöperate. The truth in these cases is usually that the physician's efforts are misdirected on account of his complete failure to understand his patient, and the patient may be suffering as acutely from pain or nausea as a result of mental conflict as another who presents demonstrable signs of pathology. To get to the bottom of such a situation often requires much patience and perseverance, and above all an ability to project oneself into the patient's situation with genuine sympathy.

The physician's job, as I see it, then, is not only to meet the needs of a sick body, but also to bolster up the spirit in that body by inspiring confidence, exuding optimism, and giving of himself in an effort to understand his patient as an individual.

Special Meeting for the Medical Society of New Jersey

Dr. Henry F. Vaughan, of Detroit, has consented to present in detail to the Medical Society of New Jersey the "Vaughan Plan", as carried on in Detroit for several years.

For this purpose a meeting will be held in the Academy of Medicine at Newark on Tuesday, October 3, at 8 p. m., to which not only physicians but all those interested in and concerned with the integration of medical and welfare administration in New Jersey are invited. Suggestions will be offered as to the practical application of the plan to conditions presented by this State.

Dr. Vaughan is the Commissioner of Health of the City of Detroit and has shown a commendable and sustained interest in the active participation of the medical practitioner in the solution of community health problems. The Vaughan Plan has received extensive attention and approval on the part of the medical profession. The precipitated discussion has brought out much constructive criticism which has furthered the development of similar plans in other places.

Of this plan of his, Dr. Vaughan says in a letter to Dr. Stanley Nichols: "Our principal objective is to secure the active participation of every qualified and prepared physician in the practice of preventive medicine in his own office. The consummation of such a plan means the gradual retrenchment in clinic service. A recent re-check indicates that we are now securing the protection against diphtheria of 47% of our infants before they reach the age of one year."

JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Office of Publication: 14 SOUTH DAY STREET, ORANGE, N. J.

Entered at the post office at Orange, N. J., as second-class matter

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, 45 Johnson Avenue, Newark, N. J.

EDITOR:

HENRY O. REIK, M.D., F.A.C.S., Vermont Apartments, Atlantic City, N. J.

Each member of the State Society is entitled to receive a copy of the JOURNAL every month. Any member failing to receive it regularly will confer a favor by notifying the Chairman of the Publication Committee.

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LEADERSHIP WANTED

In the August Journal we directed attention to the educational value of the original articles, State and County Society proceedings, committee reports, and such other material bearing upon the costs of medical care as the Journal has placed in the hands of its readers monthly since the appearance of that now famous *Report;* and, we mentioned also the possibility of continuing our course, which we then designated as a limited "study course" in medical economics. A few members having spoken favorably of the idea, we will, for this and the next issue, at any rate, abstract from the "Economic Symposium" of the recent Annual Meeting such items as we consider to be not only highly interesting in themselves but worthy of serious consideration and further study.

Returning then to the Address delivered by Dr. Ross, we find, quite *à propos* to our present purpose, a statement concerning himself which most of us will recognize as personally fitting to ourselves. Speaking of his own experience: always a private practitioner; then developing an interest in the public aspects of medicine; becoming an officer in his County Society and advancing progressively through the minor offices to the post of highest honor, President of the New York State Medical Society; he said: "Now, during all that time of self-education, I have discovered some personal limitations and among them is the subject of *medical economics.* * * * It is not, however, the simple subject it once seemed."

That point, it appears to us, is a good one from which to start our present investigations and studies. Humbly confessing our lack of preparedness to discuss, or even clearly to understand some of the more complex features of medical economics, we can the more readily receive and accept instruction or advice from those who are competent to teach—for there is no disgrace in sitting at the feet of the master. Humility and humiliation are quite different things.

As a preface to his definition of the problem now confronting the medical profession, Ross directs attention to certain facts which help to explain why medical economics have passed from the simple into the complex stage; which are fundamental to any attempt at solution of the problem; but which appear, as yet, to have been unknown to, or ignored by, many members of the profession who have spoken or written of our problems as something isolated from the World's affairs.

Concerning all this, Ross said:

"Let us keep in mind the intimate relation of medicine to social conditions and for a moment review the changed attitude of the public, and the changed attitude of government, toward social needs, and not lose sight of the fact that medicine is subject to public opinion even more than are other services.

The economic situation of the physician is a part of the socio-economic state of the world. The social function of medicine is more closely

than ever before related to the social state of the people. The relations of medicine have come into bold relief in very recent years because of the health consciousness of the people and the changed attitude of society toward its responsibility for medical service and medical care for people who cannot obtain it from their own resources.

The conservatism of medicine, desirable as it is in almost all of its relationships, has nevertheless kept the profession from fully grasping the tremendous effect of what is going on in our national affairs and in the world, and their effect upon the service of the most vital necessity in the world. We have not fully sensed the almost invisible and almost intangible influence of changed conditions. * * * Just now, as there is a possible beginning struggle between individualism and collectivism in government, so there may be something like it in medicine. We have the beginning of governmental partnership in industry. We have controlled currency, controlled prices, controlled production. We have a strengthened banking structure with weak units eliminated at one stroke.

If the present day efforts to lift the economic depression become permanent, then where is the no man's land between individualism and government? The same reasoning applies between the principles of the delivery of medical service and government but even if this is so, the regulation of details which organized medicine can plan for, if it will, may not be as undesirable as feared. To any student of the trends in government today it should be plain how rapidly as a nation we are changing. We think it applies only to business and industry but if it comes to apply to services, medicine will be the first. * * *

While *we* are all talking about *medical care,* do we realize that this country is going through a social revolution and that we have confidence in it? Apparently, the public has lost its fear of experiment in government. Social control over industry seems inevitable, and *social control of medical services may be the next step if the organized profession persists in its stand-pat position,* instead of undertaking leadership in the formulation of plans to provide medical care for those who have not means enough to pay for it, and taking the initiative in proposing a way for paying the physician for his labor.

Economic activity in business has always been regulated by supply and demand operating through rising and falling prices. This *laissez-faire* has broken down into economic disorder, but, notwithstanding all this, many physicians still think we should let matters drift. We must decide whether *we* will settle the crisis in medical care and near bankruptcy of physicians, or will let others do it. Medicine still has the confidence of the public; and if we can hold it through this crisis we will make our profession the supreme social influence in all the world. Medicine *has never before had such an opportunity to take leadership* of all health agencies in the distribution of its services as it has in this crisis—a crisis exactly comparable to the crisis in government apparently now passing.

The services of medicine must be distributed by methods under the control of the profession itself, and the profession must remain 'master in its own house'. We cannot meet the great problems confronting the profession, only in line with the time-worn traditions of medicine, any more than the general economic state can be cured by methods in line with the time-worn traditions of bankers. A *new era* may not be developing in medical care but the attitude of society will prevent a return to former conditions when this economic depression passes. * * *

We have never before had a situation just like it. Social conditions have become different. Medicine is not being *criticized* by public opinion; it is just being asked to do certain things, and being given a chance to do them. * * *

Looking over the past 25 years of the history of the Suffolk County Society, and at the satisfactory relation of the local profession to every health and welfare activity in that County during that time, we find *indications that medicine has the solution of its problems in its own hands, simply by recognizing the fair demands of the people and planning to bring them about under the leadership of the profession."*

Special Article

A PROFITABLE VACATION FOR PHYSICIANS INSPECTING A CENTURY OF PROGRESS

Despite the fact that we visited the Exposition, entitled a Century of Progress, at Chicago in connection with our attending the A. M. A. Convention in Milwaukee, and paid a hurried glance at its chief medical feature, we did not fully appreciate the extent of our profession's participation nor the amount of consideration given by the Exposition authorities to medical progress, until we paid it a second visit as a part of our vacation trip and had an opportunity to read carefully the Official Guide Book of the Fair. Being able to inspect things more leisurely during the recent visit, and to indulge to a considerable extent our hobby for photography—with particular reference at present for the making of "moving pictures"—we wish to share our pleasure and satisfaction by suggesting that as many as possible of our readers take advantage of the present opportunity to combine a *vacation* with an educational treat.

Quite aside from its medical features, there are many exhibits at this Exposition which constitute a "liberal education" in themselves. You will probably be, however, as we were, more deeply interested in the reference to the progress of medicine during the past Century, and, in consequence, we will limit ourselves here to a presentation of items abstracted from the above-mentioned Guide Book, and confine our personal statement to the single phrase that—we strongly recommend, to one and all, that you spend 1 or 2 or more weeks of vacation time in visiting this latest of Expositions, and assure you that the financial investment required will be money well spent.

From the Official Guide the following abstract was constructed:

From May 27 to November 1, 1933, the interest of a considerable part of the civilized world is focused upon 424 acres of land that lie along the shore of Lake Michigan, edging Chicago. A little while ago this site was placid lake. Now, shimmering beside the water, a dream city is risen. It lights the sky with splendor, yet soon will disappear and be merely a memory.

Only 100 years ago Chicago was a huddle of huts, hewn of logs, clinging to the shadows of Fort Dearborn for safety from the Indians, and 4 years after its incorporation as a village, in 1833, its population, conquering patches of dreary swamp, had reached 4000. Today it is nearly 4,000,000 and growing at a rate of 70,000 a year. Chicago in a century has climbed to her place as second largest city in America, fourth in the world.

It might well stir the most sluggish imagination to contemplate the fact that Chicago, born in the marshes, and actually raised, some years later, by human energy and skill some 12-14 ft. out of the mud for a healthful and more solid site, now is the commercial and the cultural capital of a domain of more than 40,000,000 people, residing within a night's ride of the city—a population greater than that of Great Britain or France, and equal to Germany's.

Chicago stands high in world notice *as a medical center*. It is the home of 6 famous libraries. Its Art Institute, which, by the way, located in the Grant Park area north of the Fair grounds, is 1 of 2 permanent institutions included in A Century of Progress proper, is visited by more than 1,000,000 people annually. The Field Museum, which stands, a $6,000,000 marble structure, at the right of the Fair grounds' North entrance, is rated as one of the world's finest museums of anthropology and ethnology. The Shedd Aquarium, within a stone's throw of the North entrance, houses a permanent exposition of marine life second to none in the world. Chicago has a $20,000,000 home of grand opera. Her Symphony Orchestra, founded by Theodore Thomas, is considered one of the finest. Her Museum of Science and Industry, established by the late Julius Rosenwald, in one of the magnificent buildings of the World's Fair of '93, in Jackson Park, ranks with the world's great museums. The Adler Planetarium and Astronomical Museum, also included as a part of the exposition, is the only one of its kind in America, and only one other in the entire world has its equal in equipment.

Lights Ahead

It is recalled as singularly significant that, in 1893, when Chicago invited the world to celebrate the landing of Columbus on the beach of a little island in the Bahamas 400 years before, there was financial panic and widespread unemployment. Since then, the world has known prosperity such as it never before imagined.

Chicago's corporate birth as a village, and the dawn of an unprecedented era of discovery, invention, and development of things to effect the comfort, convenience, and welfare of mankind, are strikingly associated.

Chicago, therefore, asked the world to join

her in celebrating a century of the growth of science, and the dependence of industry on scientific research.

Science Finds—Industry Applies—Man Conforms

Science discovers, genius invents, industry applies, and man adapts himself to, or is molded by, new things. Science, patient and painstaking, digs into the ground, reaches up to the stars, takes from the water and the air, and industry accepts its findings, then fashions and weaves, and fabricates and manipulates them to the usages of man. Individuals, groups, entire races of men fall into step with the slow or swift movement of the march of *science and industry.*

There, in epitome, you have a story that A Century of Progress tells you, not in static, lifeless exhibits, but in living, moving demonstrations of beauty and color. Science, to many of us, has been only a symbol of something mysterious, difficult, intricate, removed from man's accustomed ways. *So few of us realize that in virtually everything that we do we enjoy a gift of science.* A Century of Progress undertakes to clothe science with its true garb of practical reality and to tell its story of humanly significant achievement so that even he who runs may read.

A Century of Progress is not merely an exhibit of the products of industry. Exhibitors willingly subordinated their showing of finished products to a dynamic presentation of actual processes. They are telling a coöperative story of the ways that they utilize the discoveries of the basic sciences, a story remarkably devoid of advertising, without immediate profit in view, in complete sequence, of every phase of science. Here is innovation, perhaps a sign of a new order of things—industry joining hands to show the world the fundamentals of their craftsmanship, in a spirit of fellowship, and spending fortunes to do it. You will see *how* these basic sciences—physics, chemistry, biology, geology, mathematics, astronomy—have made it all possible. You catch dazzling flashes of what the future may hold.

And the story is made complete, its sequence a running narrative, by the exhibits of social science, which show you how Man has come up from the caves of 50,000 years ago, adapting himself to, being molded by, his environments, responding to each new thing discovered and developed. You see man's march upward to the present day, where, in a home of 1933, he uses and enjoys all the multitudinous benefits with which science and industry have endowed him.

Going Back a Century

Before you enter the Fair, it may serve to prepare your mind to keener appreciation of what our progress has been, if you simply shut your eyes and imagine yourself, for a moment, transported back a hundred years.

"Now you are traveling as man had traveled before you for thousands of years, in a vehicle dragged by animals, for—in 1833—it has been only 3 years since America's first locomotive, prophetically named 'Best Friend', chugged out of Charleston, S. C., over a few miles of track to Hamburg in the same State. So the 'steam cars' are as yet only a fearsome experiment. You live roughly, in your own tiny, lonely world, hedged in by forest or houseless prairies or towering mountains. No means of quick communication have been contrived to overcome natural barriers or to break, for months at a time, the solitude. You wear crude dress, ill fashioned, for it is still the era when clothing chiefly is made by the women of the household—it is 13 years before the invention of the sewing machine that permitted the making of clothes in volume. You eat foods that must be indigenous to the territory in which you live, for the preservation and protection of foods has not yet been developed. You read slowly and perhaps painfully by tallow candle light, for electricity has not come to work its wonders and even the kerosene lamp is in the future. You fall ill, and primitive remedies are administered, or the crude knowledge of a restricted man of medicine is sought. You live in fear and danger of epidemics which sweep the community unchecked, time and time again, and take their deadly toll. Not even antiseptics for combating infection have come, and will not until 1867. Life is cruel and harsh."

Returning to the Present

Come back to 1933. "You hurtle through the air over mountains and plains on motored wings, or speed along the ground in luxurious trains, or over smooth highways in motor-powered cars. You live in a home made of materials created by the genius of man anticipating the vanishing of forests. Electricity is your servant to give you light and do your work. You whisper and your words wing their way across the seas to be heard by listening ears. You read of an event happening a few hours before, thousands of miles away, and you see it pictured in the same newspaper. You dine on foods in their original

freshness and flavor, but grown leagues distant, and choose your food by the scales and charts of science for health and strength, and eat it in safety because science has protected it. You choose clothing of infinite variety of fabrics and patterns. You sit and watch the living likenesses of actors move about in their previously-enacted rôles and you hear them speak. You turn a dial and take music and speeches from out of the air. You may fall ill, and medical science performs miracles with the new knowledge and new devices and instruments. Life in a hundred years, in all its phases and in multitudinous ways is more felicitous, and health safer a thousand times, than it ever has been before since the world began."

The Future

Thus you conjure up the intimate picture, that with most of us has become so commonplace, of what science and industry have done for us in the common, everyday activities of life. And perhaps are moved to ask, "What does the future hold?"

Let's go back only 40 years, when Chicago's other World's Fair was held. That Fair, historians say, awoke a nation of 65,000,000 people from a lethargic material-mindedness and turned its thought eagerly to cultural and spiritual striving. Its beautiful buildings were on classical lines. Within one ornate structure crowds milled and marveled, and whispered in awe. It contained exhibits that to some were a prophecy beyond the mind's conception; to others, perhaps, merely an amazing new kind of "trick" of doubtful value or practical promise.

"The Fair", wrote an observer, "considered as an electrical exposition only, would be well worth the attention of the world." An electrical engineer is quoted as saying, "You have everything here that was undreamed of 25 years ago. You have here the culmination of invention and science. You see here the acme of modern progress. It is worthwhile to note this carefully, because if we should have another exhibit 25 years from now, the probability is that not one of the things which seem so wonderful, will then be valued. They will have been superseded by inventions so much more useful, that it is barely within the compass of any man's mind to conceive of what the future has in store for us."

Almost at Once It Happened

In less than 3 years thereafter 3 great discoveries were given to the world that completely revolutionized the whole of science!

These discoveries served to change the atomic theory with which men of science had been groping their way. They set science on the road that it travels today. Two years after the World's Fair, Wilhelm Konrad Roentgen, in Germany, discovered x-rays. A year later Antoine Henry Becquerel, in France, found the radio-activity of uranium, and paved the way for the discovery of radium. The next year, Joseph John Thompson, in England, discovered electrons by studying the nature of rays produced by electrical discharges in vacuum tubes.

So familiar to us all are the commoner uses of x-rays, and of radium, and of the vacuum tube used in our radios, that it requires no scientific or technical knowledge to instantly grasp the applied importance of those discoveries. But in theoretical science—in the laboratory of the reasearch worker—the implications of these discoveries were epoch-making. Since they were made, science has gone faster along the road toward the steady conquest of the invisible forces that rule the universe. It has succeeded in putting many new and basic devices into harness for mankind.

So fast has been that progress, in fact, that today, as you look upon the wonders of science, you wonder whether tomorrow may not hold achievements that will again completely revolutionize our methods of living.

You will see also at the Fair countless exhibits showing where science spans the gap between laboratory and factory. Among the dynamic displays, for example, you will observe the complete process of obtaining gasoline, its distillation, cracking, refining. At the same time, you will see the results of the latest research into cosmic rays that may prove—science itself will not say with certainty—the source of new power that can be taken from space. You will see, too, how sound is carried on a beam of light. Will this, in the near future, become a new means of communication? You can be the judge.

The Symbol of Arcturus

Perhaps nothing so graphically symbolizes the swiftness with which science has moved, or presents so clear-cut a picture, as the way that the World's Fair of 1893 was opened, compared with the opening of A Century of Progress. In '93, men marveled that President Grover Cleveland could press a button and start a fountain flowing, and wheels turning as the official Fair opening. At that moment, 40 years ago, the orange star Arcturus, commonly called Job's star, blinked down

upon the Fair. Light that left it then has since been racing at a speed of 186,284 miles a second earthward. The idea was conceived of opening A Century of Progress with the rays of Arcturus. A simple matter now for science to catch this feeble beam when it arrived on earth, and as it struck the great telescope of Yerkes Observatory, in Wisconsin, transform it into electric energy by means of a photo-electric cell, amplify it by the methods of radio, and speed it on to Chicago to start the big show's night life.

A miracle, they would have said 100 or even 40 years ago. But today, the "electric eye", relays, vacuum tubes, amplifiers, microphones, which respond to the tiniest fluxes of energy, help to do the work of the world in almost routine manner.

In Speech of Color

Bold splashes of color seem almost articulate with the spirit of carnival, a flaming expression of fun and frivolity which, after all is said and done, is of the very essence of a Fair. Joseph Urban, famous architect and stage designer, sought to achieve a harmony of color on building exteriors that might also express the Exposition's deeper, more lasting implications and purposes. He has used on the buildings 24 colors—1 green, 2 blue greens, 6 blues, 2 yellows, 3 reds, 4 oranges, 2 greys, white, black, silver, and gold. And it is interesting to note the percentages of colors used. Approximately 20% of all the painted surfaces is in white, 20% in blue, 20% in oranges, 15% in black, and the remaining 25% is divided among the yellows, red, greys, and green.

In terms of laboratory experiment, the result sought was a correlation of many buildings that are different in character, shape and mass, and which are arranged on a very informal plan. Too, the achievement of brightness and life for materials that of themselves are not beautiful. Were one to pose as a prophet, he might well say that here is suggestion of a future American color harmony, distinctive, bold, that could change neutral sections of cities and towns, bring cheer and liveliness to workers in factories, perhaps revolutionize in time the conception of color effects in homes. At any rate, here, color is decorative in a practical way, a planned conception to fit the architectural scheme of utilitarian modernity, and to play a part in a joyous festival.

In Style of Buildings

Consider the architecture of the buildings. Wonder, perhaps, that in most of them there are no windows. Note, curiously, that these structures are for the most part unbroken planes and surfaces of asbestos and gypsum board and plywoods and other such materials on light steel frames, rather than a parade of sculptured ornamentation.

"It would be incongruous to house exhibits showing man's progress in the past century in a Greek temple of the age of Pericles, or a Roman villa of the time of Hadrian," said members of the architectural commission of the Exposition, all of whom are graduates of the Ecole de Beaux Arts, home of the classical school. "We are trying to show the world not what has happened in the past, because that has already been effectively done, but what is being done in the present, and what may happen in the future."

Modern Planning

A Century of Progress considered two things in planning the types of building construction you see here. First, here was a city to be built staunchly for 150 days of life, not for the 30 years that is the anticipated life of a modern building. Why, then, build for 3 decades, which would be in direct contradiction to the new science of business that decries waste and extravagance, when the genius of man has provided factory-made parts, wall materials pre-fabricated in shops, steel frames and clips and screws for quick assembly, and new compositions, all to permit the building of staunch structures, which yet can be quickly razed, and the materials salvaged? And why, architects now ask themselves, should Greek pillars be used when they no longer are needed, as the Greeks used them, to be actual supports, or fanciful ornamentations or projections be clapped onto surfaces when the practical reasons which caused their use originally no longer exists?

Second, in construction as well as in architecture, it was intended that here should be a huge experimental laboratory, in which home builders and manufacturers can study, and from which they might borrow for their buildings of the future. Windowless, these buildings assure, by virtue of the advancement in the science of interior lighting, that on no day of the Fair, no matter how dark and gloomy, can visitors be deprived of the full measure of beauty in interiors and exhibits. At the same time, they may point the way for many new departures in economic construction. They exemplify, too, the advancement

which has been made in healthful, controlled, filtered ventilation. Architects and exhibitors have constant control over both light and ventilation regardless of the kind or time or day.

The portions of the E-shaped building devoted to offices and workrooms are arranged for the most efficient utilization of light and ventilation. The building is an experiment indicating possible trends in office and factory construction. Its low cost per cubic foot, the high salvage value of its materials, and its easy adaptation to everyday work, offering an army of employees few steps to climb with no need for elevators, and giving the various offices convenient access to one another, suggest many possibilities for similar structures in the future. The roof insulation is of processed cornstalks. Asbestos cement board covers the outside walls. The inner sheathing is of plaster board. Into the 2¾ in. space between the outer and inner walls, an insulating material of asphalt and wood was shot by pneumatic guns. The insulation provided by these materials is said to be equal to a 13-in. brick wall. These materials lend themselves to mass production, therefore, greater economy, and this, together with the ease of construction cut usual building costs to less than half!

In Marvels of Lighting

Should you gasp with amazement as, with the coming of night, millions of lights flash skyward a symphony of illumination, reflect again that it is *progress* speaking with exultant voice of up-to-the-second advancement. Nobody knows how many thousands of years ago, this spot that now blazes with light, was a part of vast stretches of ice. Glaciers moved sluggishly against the cold sky, and sun and moon and stars were the only illumination. Centuries rolled by and man discovered fire and used it to warm his wigwams, caves, and huts. Oils from animals came into use for lighting, then came kerosene; today we have electricity.

The Miracle of Light

A Century of Progress portrays vividly the story of Light in manifold ways. World science waits breathlessly the third exploration of the stratosphere by Professor Auguste Piccard and his brother Jean. They will soar 10 miles or more above Soldier Field in an aluminum ball similar to one on display in the Hall of Science. Who knows that they will not capture some cosmic rays which will further advance the knowledge of men. They believe it possible. Crowds can study, with Professor William Beebe, whose bathysphere is on display, and in which he descended 2200 ft. into the sea, the light that illumines the myriad life of ocean beds. They can study infra-red, ultra-violet and various other energy rays, and perhaps catch that sense of eager expectancy with which Science waits, likely upon the threshold of a new era of miracles.

Colored Lights in Tubes

A new kind of illumination has come, and in the Century of Progress it is used in greater profusion than the world has ever seen before. When President Dawes of the Exposition threw the switch on June 12, 1932, that first lighted the Hall of Science, the largest amount of gaseous tubes ever used on any one surface sprang to life. As you mingle with the throngs at night, you stand in the greatest flood of colored light that any equal area, or any city of the world has ever produced.

This color lighting is that of rare-gas tubes. You see it in blue, green, and yellow in countless signs and on billboards in letters and varied designs on your streets at home, in cities and towns and villages. This new light is produced by introducing rare-gas into a tube from which the air has been pumped, and the tube sealed, then a current of high-voltage electricity is passed through. The color radiated from the tube is determined by the element the tube contains and by the color of the tube; the red by neon in clear tube, the blue by mercury in a clear tube, yellow by helium in a yellow tube, and green by mercury in a yellow tube. True to the Fair's purpose of presenting achievements, and showing their *how*, you can go to the Electric Building and watch these gaseous tubes being charged, and bent into the shapes required.

From fireless night to the greatest display of light humans have ever seen is the span of progress A Century of Progress depicts for its visitors, and men who remember the feeble light of the coal oil lamp, or who have sat beside the flickering candle flame, may gaze and exclaim that here is illumination at its apex. But science marches on. Here, perhaps, is only a hint of what the future may produce.

The Science of Life

The spectacular exhibit that represents the science of biology in the great central hall is a mechanical representation of a section of a basswood twig, 7½ ft. in diameter. As you stand before it, you see it attain before your eyes, a year's growth in 75 seconds. The demonstration is performed by means of a series of plates and canvasses on a moving

model, showing the direction and amount of growth of wood and bast.

Moving models of the developed human being show the finished physical machine in its internal action. A life-sized model of a man explains the circulation of the blood, with a magnified heart pumping, showing the action of its valves. A simplified mechanical reproduction of the digestive system will portray the absorption of food elements by the body.

The cell theory of plant and animal-life is illustrated by some exquisite drawings by Mr. Walter A. Weber; while the storage of food in the cells of a corn-plant is shown in a dynamic model which sets forth very clearly just what sunlight does for a plant. In the south wing of the Hall of Science will also be found the rare screen-pictures by Mr. George Roëmmert in which he projects for his audience, not a series of lantern slides or films, but those minute forms of actual living animals and plants just as they would be seen by an observer looking through a microscope of very considerable power.

Modern views of inheritance, the evidence for evolution and the physiology of the human frame are presented in a concrete way that demands careful study.

The "Clock of the Ages"

The science of geology is epitomized by a giant "Clock of the Ages" which ticks off the 2,000,000,000 years or more of the earth's history on a conventional clock dial. Geologic pictures appear on a screen in the center of the clock face, and they are described by a synchronized phonographic record. The visitor also sees operating models demonstrating the formation of mountain ranges, the growth and activities of volcanoes and the eruption of geysers. Further, he is initiated into the mysteries of earthquakes and the ingenious manner in which man has forced them to write their own records. A large group of spectacular displays of similar type, representing earth features such as the Yellowstone Geysers, the Grand Canyon and the Carlsbad Caverns, are being furnished by the National Parks Service.

The romance of oil is revealed in a great sequence of operating exhibits sponsored by the American Petroleum Industries. These displays cover every phase of oil and gas production. Other exhibits explain man's modern, almost magical, methods of locating the deeply buried raw products which formed the basis for his century of progress.

Science in Industry

Everywhere the visitor turns—here, and throughout the Fair—he finds the application of science's discoveries in industrial benefits for humankind. For example, the visitor sees a real rubber tree brought all the way from Africa, from which the rubber latex seems to flow naturally. He sees the coagulation of rubber with formic acid, and then its electroplating—a relatively new process carried out by combining the electrically neutral rubber with carbon, so that it can be deposited by an electric current on the linings of chemical receptacles, tanks, and the like. There is shown also the vulcanizing of rubber, and the nature and uses of accelerators, pigments, and antioxidents in the processing of various kinds of rubber.

Again, industry shows the actual process by which coal tar is transformed by chemistry into dyes; how perfumes, and medicines, including antiseptics and anodynes, and T. N. T., and other things, are made from the 12 primary substances which coal tar contains.

Thus, the visitor sees the fundamentals of science, and then sees their step-by-step progress to the finished product that contributes so much to his well-being, and comfort, and health.

The Story of Medicine

Here one finds himself in the midst of the 3 important branches of medical science, namely medicine, dentistry and pharmacology. Here, too, one finds a science which uses the best there is in each of the other sciences and then some. Dr. E. J. Carey, who has managed the collection and installation of these exhibits, has depended mainly upon the various institutions, such as universities, clinics and scientific societies. No exhibit in the entire building has more of human interest or is more cosmopolitan in character than these rooms in the north end of the ground floor devoted to the detection, the cure and the prevention of our bodily ills.

At the east end of the ground floor there stands a giant man. He is 6 ft. tall, and rises from a pedestal 3½ ft. high. He is transparent. As though you were suddenly endowed with x-ray eyes, you may view the inside of the human body.

This transparent man, composed of cellon, and brought to A Century of Progress from Dresden, Germany, is 1 of only 2 in the world, and required 18 months to make. He cost $10,000. He properly begins the story of the science of medicine in this theater of the sciences.

An exhibit of the great Pasteur, sent by the Pasteur Institute from France, looms to your right, as you stand facing the Transparent Man. This exhibit, an illuminated map of the world supplemented by photographs, tells the story of the life of Louis Pasteur, and some of his accomplishments.

To the right, you will see an exhibit sent from Germany by the Robert Koch Institute, which displays the life and the work of the great man who discovered the tubercle bacillus in 1882, and started medical science upon its studied campaign against tuberculosis.

Eyes left, and you see a remarkable exhibit of the Wellcome Research Institution, from England. It tells the story of the work of Sir Henry Wellcome, American, who fought the mosquito in Africa and won, and laid the way for extermination of yellow fever. The Wellcome Historical Exhibit, a museum in itself, shows you dioramas that illustrate epoch-making events in British medicine and surgery.

Northwest of the Transparent Man, the Italian exhibits show you Italy's great pioneers of the 3 basic medical sciences—pathology, anatomy, and physiology—respectively, Leonardo de Vinci, Morgagni, Spallanzani. With models and apparatus they tell you something of how these men, and Galvani, and Malpighi, and Vesalius, lit the lights by which the men who came after them charted their course, for the welfare of mankind.

Northeast of the Transparent Man are exhibits recording medical triumphs of research workers in the United States. Austria, Holland, Canada add their contributions, and you have an absorbing, yet colorful story to study, and to carry away with you for a lifetime of reflection. Thus, the Transparent Man stands as a symbol of world medicine, a common denominator of the nations.

You may see in the Austrian exhibits the work of Austrian scientists, and in those of Holland the structure and function of the nervous system told in a simple, dramatic way. In the Canadian section, McGill University, through murals, transparencies, and photographs, portrays the history of James McGill, and the development of the Montreal General Hospital and its work, and of the work of Sir William Osler.

It was at McGill University that the first surgical x-ray photograph was taken, 2 months after Roentgen announced his discovery in 1895. The photograph itself is shown.

You can go back to 1550 B. C. and read descriptions of more than 700 different remedies for human diseases, in the exhibits of the American Pharmaceutical Association. You can watch the antics of an Indian medicine man, practicing his primitive medicine, in the exhibits of the Milwaukee Public Museum. Marquette University of Milwaukee shows you a history of Bright's disease, and the progress medicine has made to prevent and cure it.

The American Medical Association shows you the progress of medicine in the past 100 years—the old saddle-bag doctor who went his lonely way, measuring out his meager doses in sparsely settled sections, and the physician and surgeon of today with his highly technical equipment. The American Society for the Control of Cancer shows the advance science has made to frustrate the ravages of this dread disease; the Chicago Municipal Sanitarium and the Chicago Tuberculosis Institute tell you of the strides that have been made to subject this disease to control. Cleveland Clinic Foundation shows motion pictures illustrating the discovery of the circulation of the blood by Harvey in 1628, and of blood transfusion, and of the functions of the thyroid, suprarenal, pituitary, and other glands.

It's difficult to believe that Oliver Wendell Holmes had to fight to persuade the public that doctors should exercise cleanliness in childbirth, but Harvard University tells this story in its exhibits.

Dr. Crawford W. Long, of Georgia, first used ether in 1842, and the University of Georgia tells you the story and shows you the development of the use of anesthetics in modern surgery.

The Mayo Foundation develops 3 themes in its extensive displays: (1) Diseases of the digestive tract; (2) the thyroid gland; (3) the sympathetic nervous system.

A striking exhibit, expressive of the progress of medicine in the past century, is that of the Chicago Board of Health. In 1849, the general death rate was 73.8 per 1000 persons, in 1932 it was 9.8. The typhoid fever death rate in 1891 was 173.8 per 100,000, today it has an amazingly reduced rate of 0.4! The Chicago Medical Society and Woman's Auxiliary show you the medical history of this youth of cities. The New York City Cancer Committee shows the history of the magnificent fight that science has waged and is waging against this malignant disease, and the University of Illinois College of Medicine, College of Dentistry, Department of Animal Husbandry, and the Illinois Department of Public Health, give interesting sidelights on methods of treatment and causes of hay fever, tuberculosis, pneumonia, hemophilia, and rabies. The Illinois Public Health Service shows con-

trasting pictures of methods of sanitary hanling of milk today, and of insanitary methods of other days; and presents also the health conditions of 100 years ago, compared with those of today.

The University of Chicago presents an inspiring display showing the giant strides that practical humanitarianism has made in reclaiming the crippled child for work and for enjoyment. Loyola University of Chicago shows the organs of the human body for easy understanding and study. The University of Wisconsin shows the work of Beaumont, the first American physiologist, whose experiments upon poor Alexis St. Martin, French voyageur, up in the woods of Wisconsin, in 1883, contributed so largely to the advance of medical knowledge in the treatment of digestive disorders.

Exhibits in Dentistry

In the large dental exposition, you will see the denture, controlled by heavy springs, with which George Washington, in his later years, laboriously chewed. You may read, for a conception of the simplicity of early American dentistry, the advertisement of Paul Revere, goldsmith, printer, engraver, and dentist, offering to make false teeth "that look as well as the natural, and answer the end of speaking to all intents". The development of dental science, which is typically American, is illustrated by an exhibit of equipment of the itinerant dentist of 1833, and a fully equipped operating room of the period of 1933.

U. S. Public Health Service

The U. S. Public Health Service has an extensive exhibit, which contributes further to the story of medicine's progress, in the U. S. Government building on Northerly Island. This exhibit, occupying 2500 sq. ft. of space, shows the progress made in public health and sanitation since the establishment of the service. It is presented in divisions and shows the work of the service in combating pellagra, tularemia, undulant fever, typhus fever, spotted fever and parrot's disease. The exhibits extensively demonstrate the vast efforts the government has made, and the methods used, to exterminate disease.

Scientific Exhibits by Foreign Nations

The visitor who returns to the north wing on the main floor will be splendidly rewarded for time spent in the bays occupied by Italy and Denmark. Each of these countries has a wealth of fundamental discoveries to its credit; and these are here shown in a concrete and highly interesting form—for example, a section, in replica, of the ancient Roman vessel recently rescued from Lake Nemi, after 2000 years under water; and a replica of the simple compass with which Oersted made the brilliant discovery of electromagnetism.

The Unity of Science

A visitor who has completed a trip through the Hall of Science can hardly fail to note that amidst the variety of phenomena, apparatus, and processes here displayed there runs one common feature, namely, the method of modern science. The problems differ, the materials differ; but in every case there is clear vision as to just what the problem is; that is followed by observation and arrangement of apparatus in such a way as to compel Nature to give an answer.

The Adler Planetarium

In the Hall of Science, you will have seen the fundamentals of mathematics and physics that properly lead into the science of astronomy. Now you may cross over the Science Bridge, if you wish to finish the story of the basic sciences all at once, turn to your left, and go to the northern end of Northerly Island where stands the Adler Planetarium and Astronomical Museum.

This rainbow-granite building with its mushroom dome is world famous, for within it is an intricate mechanism called the Zeiss projector, the only one in the United States, and again 1 of only 2 in the world. With this instrument is staged a spectacular drama of the heavens. Once every hour, visitors are admitted to a circular room to sit beneath its domed white ceiling. The light is flashed off. The ceiling becomes a blue sky, sparkling with millions of stars seeming so close and so real that you feel that you can reach up and touch them. A lecturer tells you about this firmament. His pointer is a beam of light. Behind him is a concealed switchboard, with which he controls the apparatus. You are permitted to look ahead into the future and know where the Pole Star or any other heavenly body will be situated at a particular minute of a particular day decades or centuries hence. You can look back into the past and see the heavens as they appeared when Christ walked on earth or when Galileo studied the stars with the first telescope.

Should you arrive while a lecture is in progress, you can entertain yourself by strolling about the halls or exhibit rooms downstairs. The Planetarium, which is under the direction of Prof. Philip Fox, formerly of Yerkes Ob-

servatory, and formerly Professor of Astronomy at Northwestern University, has a wonderful collection of instruments which men of science in centuries of the past have used. Four hundred years ago the Strozzi family of Florence began a collection of scientific instruments, gathering and preserving those of worthy achievement. About 40 years ago this collection passed into the hands of Raoul Heilbronner in Paris, and after the World War to W. M. Mensing in Amsterdam, and from him to the Chicago museum.

Downstairs you can push a button, and see exactly how the light from the star Arcturus could be caught by a photo-electric cell on arrival from its 40-year journey to earth. You see a model of the rotating prisms with which the late Albert Michelson of the University of Chicago showed the velocity of light.

From Wagons to Wings

It has been only 64 years since 2 sweating gangs of laborers met near Ogden, Utah, May 10, 1869, in a thrilling race from east and west, and drove the golden spike that completed the span of the continent with iron bands.

At that time there were less than 40,000 miles of railroad in this country. Small, slow engines yanked crude cars from coast to coast, but the nation could hail them as wonderful monsters of progress. Crowds came in rattly buggies to watch the trains go by, or gratefully hauled produce to sidings in horse-drawn wagons, a market found at last, and the "Iron Horse" pounded out the beginnings of communities, cities, a wider civilization. For the first time, the west, and east, and north, and south were welded together, as one great country. Then, 35 years later, the horseless carriage chugged its way into existence. And now the cities and towns and farms were welded even closer, this time by speed and convenience that made it possible for farmers to get to towns and to cities, in little time, and residents of cities and towns and the farms to go places whenever the whim seized them. Came then, the airplane to laugh at miles and make it possible to cross the continent from sun to sun. In less than the Biblical allotment of the years of a man's life, these modes of transportation have played a mighty part not only to permit the growth of a nation, but profoundly to affect its industrial, its political, its economical, even its spiritual life.

For the first time in architectural history a dome has been constructed on the principle of a suspension bridge. Just as a suspension bridge has no pillars, columns, or arches to support it from below but depends on cables to carry its load, so the dome of the Travel and Transport building is suspended 125 ft. above the ground by cables attached to 12 steel towers. The reason for the daring use of this suspension principle was the necessity for a clear, unobstructed space for exhibits. The result is a demonstration of how the desired result may be satisfactorily achieved at a much lower cost per cubic foot and we have a dome with an interior diameter of 310 ft. at the base, and 206 ft. clear of any obstruction.

This dome is made with joints that allow for expansion and contraction as the temperature varies, resulting in a variation in circumference of more than 6 ft. The roof rises or sinks as much as 18 in., depending on the amount of snow or atmospheric pressure on the roof. This has given rise to the name—"the dome that breathes".

When your attention is turned to the exhibits themselves the first thing to greet your eyes is a mammoth crown, surmounting a pillar, from which 4 projection machines throw motion pictures upon a ring of screens, 30 ft. high, around the walls. This 630 ft. of screen forms the stage for the story, in filmed detail, of the essential contributions of oil to the powering and lubricating of transportation.

You may wish to pause and see "Old Number 9", the first sleeping car ever built, a little wooden car with open platforms and crude berths, that looks a bit humble as it stands between 2 great modern Pullmans, all of aluminum, and stream-lined, which are the last word in sleeping car construction for 1933. But little No. 9 can be proud of its history. First to be built, it made its initial run from Bloomington, Illinois, to Chicago in 1858. And later it was a part of the train that bore the body of Lincoln to Springfield for its final rest.

And here's an old stage coach, scarred by bullets and Indian arrows, a Rocky Mountain stage coach that could tell many a tale of bandits and red-skin raids. Nearby, an original Conestoga emigrant wagon, in which pioneering families slowly moved toward new and ever new horizons, braving death and hunger and suffering.

And here is a horse and buggy. Nearby one of the old buggy-type automobiles, first of its breed, startling contrast to its modern lineage, to be seen further on in the exhibits.

On tracks, under roof, are a glass-lined, steel refrigerated milk tank car, built for speed to rush milk fresh and sweet to modern homes, far cry from the old horse-drawn milk wagon, and tin milk cans. Also are exhibited a model

refrigerated meat car and a dry-flow tank car for products such as cement and soda ash.

The Automobile Link

A "glass automobile" makes a striking exhibit, showing through 9 panels of glass the parts of the machine in action while an electric fountain illuminates them with colors.

The Age of Aviation

A great illuminated map tells one in swift summation the amazing growth of aviation since its comparatively recent birth, showing a lighted network of airways serving 44 states, and dramatically exhibiting the night flying operations. The map illustrates the increase in travel by air since 1926, when 4,600,000 miles were flown, to 1932, when 50,000,000 miles were flown, 40% of which was night flying.

Striking Exhibits in Outdoor Area

South of the Travel and Transport building, is an outdoor area for exhibits. You can see one of the fastest and most luxurious trains in all of Europe, the "Royal Scot", crack train of the London, Midland and Scottish railways. This train makes the run from London to Edinburgh in 8 hours regularly.

On one side of the "Royal Scot" stands a gigantic Chicago, Burlington and Quincy locomotive at the head of a U. S. Railway Post-office car, chair car, diner, 2 sleepers and solarium lounge car.

On the other side of the British train are the air conditioned cars of the Baltimore and Ohio Capitol Limited, representing the eastern roads of the United States.

On the next track are the palatial special coaches of the Presidential train of the Republic of Mexico, which are considered by many to be the most luxuriously furnished cars in the world. On display in one of the cars of this train is a priceless collection of jewels, the famous Monte Alban gems. These gems have been traced back to early lapidaries of the ancient Mexican civilization. They comprise ornaments of jade, jet, ivory, amber, bone, and the like, set in gold, recently recovered from ruins and rubble.

One of the largest freight locomotives in the world is shown by the Delaware and Hudson Railroad.

A demonstration of mine rescue equipment and its use is shown nearby, in a U. S. Bureau of Mines rescue car, and General Steel Castings Company show a new type gondola car of unique construction.

A Tractor Run by Radio

A farm tractor crawls about a 2-acre field, controlled in its maneuvering solely by radio, from a switchboard at the edge of the field. This is the exhibit of the International Harvester Company, which also shows operation of cultivating and harvesting machinery on simulated crops.

A Glass Tower Parking Place

A glass tower of the Nash Motors is a spectacular feature of the outdoor exhibit. This parking tower, built by the Whiting Corporation, coöperating with Nash Motors, is 80 ft. tall, and it carries 16 cars, each car in a pocket, its full height. Colored lights bathe the tower, and Nash cars pass up and down in continuous movement, bringing each car into a glass-fronted show room at the tower's base.

General Motors Building

The part that automotive engineering has played in our civilization is graphically represented in the General Motors building.

The building is ⅛ of a mile long and 306 ft. wide, surmounted by a 177-foot tower, brilliantly colored, and illuminated. The central feature of the building is a complete automobile assembly plant, to the rear of the display rooms, where 1000 people at a time may witness the assembly of automobiles. Raw materials enter through one door and by the time they reach the opposite exit, they have become finished cars. *A visitor may select the materials for his car as it enters the door, follow its progress along the assembly line, and get in and drive it off at the other side of the room.*

ELECTRICITY

The Servant That Has Transformed the World

In the court a fountain sends up iridescent jets of illuminated water in a series of multi-colored steps. Out of the center of the fountain rises a 70-ft. canopy. The under side, of hammered copper, chromium plated, reflects the color and disseminates it, and achieves a superb beauty.

This is the court of the Electrical building. The great building itself, in semi-circular form behind the court, connects with the Radio and Communication building. A group of pylons rises, with a giant bas-relief panel on either side, 40 ft. high, on which figures are sculptured in such mammoth size as to suggest the enormous forces they symbolize. One represents Atomic Energy, bearing the inscription:

Energy is the substance of all things—the cycles of the atoms, the play of the elements are in forms cast as by a mighty hand to become the world's foundations. The other panel symbolizes Stellar Energy, and bears the inscription: *Light is the beginning of all things. From the utmost ether it issues, shaping the stars, answering in its patterns to the majesty of creative thought.*

There is an entrance here, which leads to a great circular hall. Another entrance is on the west side from a water gateway, flanked by 2 huge pylons more than 100 ft. high, and a wide stairway leading up to the hall. This water gateway provides a landing for visitors who come from the mainland by water across the lagoon. On these pylons also are sculptured figures, *Light* on the north pylon, *Sound* on the south one. Perhaps, if you come from the Hall of Science, where you are told that electricity is simply the movement of electrons, migrating away from the infinitesimal atom, the dazzling spectacle of Electrical Court, and the illumination of its buildings, and the vast and spectacular compositions of light that flood the Fair may awe you by the very stupendousness of the story electricity tells in this phase alone of its myriad activities.

But the story within these 2 buildings, of which Raymond Hood was architect, is more stupendous still. Here, for example, you will see demonstarted the new "fever machine", a gift of science to medicine with which hospitals are experimenting now, in the hope that it will be of incalculable value in the treatment of many diseases. Photo-electric tubes—the "electric eyes" we have seen demonstrated so startlingly throughout the Fair—are made to do tricks that demonstrate countless possibilities.

A high frequency furnace is shown, and you see a new blade quickly melted, while the hand which holds it, in the same furnace, is uninjured.

You see an incandescent light no larger than a grain of wheat, a marvelous aid to surgeons. Also the world's largest incandescent lamp, of 50 kilowatts. You see sun lamps as they are used in the poultry industry, and in hospitals, schools and offices.

Beneath the floor, seen through a glass walk, a model section of the world's largest water-wheel generator rotates in a flood of light. Again, here is a huge model of a transformer, the largest ever built. There are extensive displays of electric equipment and lighting effects, model kitchens, model laundries. Models of great ocean liners are paired with an open model of the electric equipment that propels such liners.

An Amazing Diorama

On the mezzanine, the largest diorama in the world tells you a thrilling, inspiring story. Suddenly the great scene, 90 ft. long, leaps into life. Reservoirs in the mountains take the flow from moving rivers, turbines begin to spin, across the plains lights in lonely ranch and farm houses glow in the dusk; the movement races on into a city that takes on life, the streets imbued with activities inspired by great industries, tall sky-scrapers, homes and hospitals, stores and factories, theaters, churches, rushing elevated trains and subways. A steam electric-generating station with switch-yards leading into it, and trains running; an airport, and planes *live*. On to another city, from coal mines to farms, to quarries, to many other places of industry now served by electric power goes the precious current.

A voice speaks out of the darkness, explaining. And thus, in moving drama, you get the story of electricity from its generation, to its varied service of dispelling darkness, driving machines, and serving households in myriad ways, made possible by hydro-electric transmission. The first hydro-electric station in the United States was built just 50 years ago, near Appleton, Wisconsin!

Other striking exhibits you see here on the second floor are full-sized rooms of homes, showing the many uses of electricity in the home; farm buildings, showing farm electrification—its uses on the farm from bug killing to silo filling and powering of machinery. Five model stores tell a graphic story. Electric furnaces that have made possible the utilization of cast iron, and other demonstrations of the applications of electricity in power, heat and light in industry are shown.

The Radio and Communication Building

When Raymond Hood planned this building, he had in mind the close relationship between communication and the industries devoted to generation, utilization and distribution of electric power. He symbolized their union by joining their buildings.

Leaving the great hall of the Electrical building, you step into the radio show, where are demonstrated the mysteries and the fascination of world-wide reception.

The small boy who has just begun to tinker with batteries and receivers, or the seasoned adult who has kept up with the swift development of this new science, will each find the points that interest them simply and graphi-

cally told. The show culminates in a display of novel and "trick" sets, and apparatus hinting of future developments. On the balcony of this connecting link, also, you will see a reproduction of a Hollywood movie set, and some interesting motion pictures of the World's Fair itself.

Inverted Speech and Magic Answer Board

Entering the communication area, perhaps your attention might first be attracted by the "Bird Cage", where you see demonstrated what is called accoustical illusions. You speak in a low pitch, but you hear it high, and vice versa; you hear speech inverted so that it becomes unintelligible when received over the ordinary radio set. In another exhibit you learn how privacy is obtained in radio telephone conversation. Other exhibits show you the mysteries of the dial telephone, and how operators handle your telephone calls. You see 12 conversations carried on simultaneously over a single pair of wires, and an oscilloscope shows you the wave form of spoken words, and then of musical notes.

You may spend hours in this great building, hours of fascination and delight, and perhaps of awed wonder that in less than a century all these miracles of electricity have come. And then turn perhaps with something of reverence to a building that sits on the edge of the Lagoon, adjoining these Electrical buildings—a memorial to Thomas A. Edison.

The Edison Memorial

It was in 1879 that Edison, watching a charred cotton thread in a glass bulb glow for 40 hours, ushered in the new era of light. Steinmetz, another great electrical genius, declared that Edison had done more than any other man to foster the growth of electrical engineering. And so, tribute is paid to him, in the only building in the Exposition erected to the memory of one man, in the Edison Memorial. It houses displays setting forth the many evidences of his inventive genius, and their effect upon the world. About the building is a beautiful garden brought from Edison's home in Orange, New Jersey, where the "joyous inventor" spent most of his leisure time.

Beautiful Homes of Today and Tomorrow

Though not technically a part of the Social Science group, a culminating chapter of the story could center in Home Planning Hall and a group of 11 houses designed to show progress in architecture, comfort and economy.

Grouped around the buildings on the lake front, with appropriate landscaping, are 11 exhibit homes, 8 of which illustrate in a modern way, to the family of limited means, the use of pre-fabricated building units, new materials, and new methods of construction. All these small houses are designed without cellars and with integral garages. All but one are constructed with flat roof decks and solariums which make maximum use of sunlight for health and enjoyment. All seek to cut the cost of small home construction and provide greater living values.

Most of the group were produced by manufacturers to illustrate use of their materials, yet architects and decorators have had full play in carrying out the theme of progress, wholly aside from the commercial factor involved.

Armco and Ferro Enamel House

This house was built for the American Rolling Mill Company and the Ferro Enamel Corporation, by Insulated Steel, Inc. This house is unique in that it is frameless; no structural steel being used. The walls are box-like units, factory fabricated, house high, and welded at the shop in various widths. When set up, the walls are filled with rock wool. The exterior is panels of vitreous enamel iron nailed on with "belyx" nails. There are 7 rooms, bath and lavatory, and integral garage. The deck roof gives space for a solarium and open porch. Cost, exclusive of equipment, $4500. Interiors by Kroehler Furniture Company and Ladies Home Journal.

General Houses, Inc., House

Another all-steel, frameless house, with nothing made at the site except the concrete piers. The steel chasis was set in place, and the panels bolted on to form a complete shell; then the roof panels were bolted on, windows and doors installed, and the house was ready for paint. It has been estimated by the General Houses, Inc., that these simple units make possible an almost endless variety of designs, and that a week's time could suffice for the erection of a 4 or 5-room house. Cost, exclusive of equipment, $4500.

Good Housekeeping-Stransteel House

A steel frame house of highly modern design, with a large recreation room on the second floor. The exterior is enamel-finished steel, backed with Haydite and fastened with nails. The large recreation room on the second floor gives access to the terrace, which covers the greater part of the flat roof. Cost,

exclusive of equipment, $7900. Interiors by Good Housekeeping Studio.

Rostone House

A 6-room house built by Rostone, Inc., and the Indiana Bridge Company. Rostone is a building material composed of limestone and shale, and can be had in any color. The material is pre-fabricated in standard sizes. The house has all the living quarters on the first floor, with a glass-enclosed solarium occupying a fourth of the space of the roof deck, which covers the entire house. Cost, exclusive of equipment, $6000.

"Design for Living"

John Moore, of New York, was the architect and builder of this unusual home. It is of 2 stories; the first includes a large living room, with 2 L-wings, one a commodious dining room and the other a library study opening on a large porch. The upper floor holds 2 bedrooms with bathroom between. The full length of the house is occupied by a roof terrace, giving room for outdoor sleeping, and for recreation. Cost, exclusive of fixtures and equipment, $4000. Interiors by Gilbert Rohde, interior designer, New York.

Masonite House

This house was built by Masonite Corporation, with Frazier and Raftery, Chicago, as architects. It has a living room with 12-foot ceiling and large groups of windows on 2 sides. The dining bay is part of the living room, with a group of windows, centered by a French door, leading to a terrace. Two bedrooms and bathrooms are also on the first floor, with a wide hall and staircase giving access to the den upstairs and the covered and open decks of a modern roof. The walls of one of the bedrooms are covered with broad-loom woven cellophane, with hangings of knitted cellophane. Cost, exclusive of equipment, $7500. Interiors by Marjorie Thorsh, interior decorator, Chicago.

Lumber Industries House

The National Lumber Manufacturers' Association built a 5-room dwelling, modern in design, and *walls and ceilings are paneled with various woods,* achieving unique designs and demonstrating logical lumber uses. Cost, exclusive of equipment, $4500.

"House of Tomorrow"

A *circular glass house,* incorporating possible indication of what the future may bring in housing, has been built around a central mast which contains all utilities. The exterior walls are of *clear glass,* and there are no windows. Privacy is obtained by drapes and roller and Venetian blinds. The most modern equipment available has been used, including everything from an airplane to electrically controlled doors. The furniture is especially designed. The ground floor includes the airplane hangar in addition to the garage; the roof forms an extensive deck terrace, opening from the living room floor, and there is a similar deck around the drum-shaped solarium on the third floor. The ventilation is all by filtered, washed, heated or cooled air, re-circulated every 10 minutes. There are no visible light fixtures, as the necessary artificial light is indirect, from hidden sources. There are no closets, but movable wardrobes are used.

The house is frankly declared to be a "laboratory" house, for the purpose of determining the attitude of World's Fair visitors to the idea of an utterly different home. Future homes of the type, it is said, could be built at prices within the range of the other small houses in the group.

The Glass Block Building

An unusually constructed building, by the Owens-Illinois Glass Company, is of glass blocks, with a central shaft 50 ft. high. The glass blocks are many colored, semi-transparent, and approximately the size of the ordinary paving bricks; the colors fired into the glass.

In Conclusion

We could, of course, go on indefinitely describing interesting features and events typifying this Exposition, but let's hope that this much has been sufficient to have effected one purpose—that of inducing all who can to utilize this opportunity for a profitable vacation.

Medical Ethics

KEEPING OUR OWN DOORSTEP CLEAN

John Hammond Bradshaw, M.D.,
Orange, N. J.

> Let each one sweep in front of his own door, and the whole world will be clean.
> —*Goethe.*

It is not necessary to be a philosopher or a poet, as was the writer of the above lines, to understand their profundity and their

ethics. The matter can be put in many different ways: first, *mind your own business;* second, try to make the world brighter and cleaner by doing your own part; third, do not try to sweep your neighbor's doorstep, etc., etc.

One would think that minding one's own business would be man's first, if not only concern. To the man who minds his own business, with concentration and persistency, the rewards are sure and sometimes great. It is so easy to blame our misfortunes and even our evil doings on others, that we often fall into this mistake. But we must sweep our own doorstep. If we do this, it is surprising to find how many of our troubles we shall sweep away.

If we do our own part in our sweeping, we will help the world to recover from its dislocation. There is no doubt that recent years have witnessed this dislocation. Pessimistic people have even predicted permanent disaster. If each man sweeps his own doorstep, such a disaster, such a calamity and misfortune will be impossible. But you must do your own part. There is no escape. Just as truly as no man can eat your food for your own benefit and nourishment, so no other man, on all God's earth, can tell you always the right place to get off. This you must do for yourself if you want to keep your place in the sun.

All the foregoing deals with you, yourself. Now the world was not made for you alone, but you were made (with others) for the world. From your own standpoint, however, you are perfectly right in looking out for your own welfare. On the other hand, you must not forget that the earth contains other people, other nations, and holds many other interests besides your own. If you forget this, you are doing yourself as well as them an injustice. This is such an axiomatic proposition, it seems funny that we often do forget it.

Now why, in Heaven's name, should you go to the trouble of sweeping your neighbor's doorstep? Do you not have enough to do at home? Does it make any difference to you if your neighbor prefers that his doorstep be dirty (personally, morally, or politically)? He is the one who will suffer most. Yes, you are, in a sense, your neighbor's keeper. But *mind you keep off your neighbor's doorstep.* Perhaps if you do, he will glance over at your clean steps and will think that after all his own had better be clean. But don't tell him so. Don't tell him to go to hell. He might go and drag you along with him! Selah!

In Lighter Vein

Doctor Abbot's contribution to the field of thermatics is called the "kampometer". It is so sensitive and so delicate it is capable of measuring the bodily temperature generated by a kiss.—Los Angeles Examiner.

Sensitive, yes. Delicate, no.

Prof. Einstein arrived here accompanied by his wife, a sizeable cargo of luggage, and his ever-present violin.—Pittsburgh Sun-Telegraph.

No side remarks, please!

For the benefit of his patients Dr. A. Hardaway announces that he will be absent from his office during the next week or ten days.—From a North Dakota newspaper.

That's not time enough to get much strength back.

Coals to Newcastle Department

I went to the "Tiergarten" which is German for zoo, and means animal garden. I can't make up my mind whether it is better than the Bronx zoo or not.

It's very interesting to study the habits of the animals, too. I think it improves your mind, and makes you understand human beings better. It's a regular education to watch the way the males treat their females, and vice versa. It gave me some real, deep ideas about life.—Clara Bow quoted in Photoplay Magazine.

Put and Take

"Women take to good-hearted men", says a writer. Also from, say we.—Boston Transcript.

Rapid Transit

St. Peter: "How did you get here?"
Citizen: "'Flu!"—Everybody's.

Cook's Vitamins

'How is it the biscuits were so hard this morning, Mandy?"

"I'se sorry, ma'am, but Ah ain't feeling right pert this mawnin'. My system's kinda run down, so I eat the only yeast cake there was in the house."—Boston Transcript.

Darn 'Em Both!

I put my money in a sock,
The sock it had a hole;
I wish now I had used a bank,
For I have lost my roll.

I put my money in the bank,
I wish I'd used my sock;
For fate stepped in with playful prank
And put that bank in hock.
—Birmingham Age-Herald

Might Blow a Bunch of Scrip

He threw a dollar 'cross the stream,
A feat that was a wow;
But if Washington were back again
He wouldn't do it now.
—Buffalo News

I am exceedingly inclined
To side with you, by gar!
In my experience I find
It wouldn't go that far.
—Newark (Ohio) Advocate

Current Events

TRI-STATE MEDICAL CONFERENCE

Philadelphia, Pa.,
June 24, 1933.

The Tri-State Medical Conference was held on June 24, 1933, at the Union League Club, Philadelphia, Pa., and called to order at 10.30 a. m. by the Chairman, Dr. Charles Falkowsky, Jr., of Scranton, Pa., President of the Medical Society of Pennsylvania.

Those in attendance were: from New York—Dr. Joseph S. Lawrence, Albany; from Pennsylvania—Dr. Charles Falkowsky, Jr., Scranton; Dr. Donald Guthrie, Sayre; Dr. H. W. Albertson, Scranton; Dr. A. C. Morgan, Philadelphia; Dr. Edgar S. Buyers, Norristown; Dr. W. F. Donaldson, Pittsburgh; Dr. F. C. Hammond, Philadelphia; from New Jersey—Dr. J. B. Morrison, Newark; Dr. H. O. Reik, Atlantic City. Guests present were: Drs. S. McC. Hamill, J. Newton Hunsberger, and Wilmer Krusen, all of Philadelphia.

Sickness Service Echoes from the 1933 Session of New York State Medical Society

Joseph S. Lawrence, M.D.,
Albany, N. Y.

Dr. Lawrence: Mr. Chairman, I am prepared to give a brief outline of what we are doing in New York State, particularly with regard to the emergency that now exists.

During the past 4 years the State has revised its welfare work completely. We have enacted a new welfare law which carries with it provision for medical service in a way that was never suggested in the old law. The suggestion in the law was to abandon institutional work, if possible, and make medical care a feature of home relief. It is appreciable, of course, that such a plan is ideal, and that one cannot get absolutely away from institutional work, but the use of the word "Almshouse" has been abandoned and "County Hospitals" substituted, so that when home relief is not practicable, the patient will probably go to a County Home, or, if he does not do that, he may receive service in a County Hospital while remaining at home. Such home relief must be paid for by the local welfare officer, and the law provides that welfare work shall be a County matter if the County so elects. A County welfare officer may direct and supervise all the welfare work in his County if it is working under that scheme. Several counties are organized on that plan. However, where that does not prevail, then modification of the old system will be in effect; that is, the township shall be the unit and the welfare officer of that township shall provide the necessary care and shall pay for it from funds allotted to him for that purpose. He may provide *medical* care according to his own judgment, but *hospital* care must always be a County matter.

In regard to providing medical service, the old method was to have what they called a "poor" doctor, who was employed by the Board of Supervisors, and who, naturally, did as little work as he could get away with. There is nothing to prevent a town or county from employing physicians on salary to do welfare work; but the law, in several places, indicates that that is not the preferred method, and in one place states definitely that poverty shall not be a cause for disrupting any family or preventing the family from having such services as would tend to maintain its integrity. So, medical relief in the home is much preferred to institutional work, and by the family physician as against an employed physician. Much of our relief work is being done according to that plan. The family physician is employed by the welfare officer to do the work where it is convenient for him to do it. If, however, the family physician resides too far away, so that travel expense would be a large item, then, if there is no other reason against it, a nearby physician is employed to render the service, the idea being to prevent great sums of money being expended on travel service and have that money concentrated on immediate service to the family.

In the first, second and some of the third class cities, this system cannot prevail. Of course, the cities have their own welfare organizations, and they have what they call "City Physicians", men employed on salary and, of course, the family service so rendered is not ideal. However, that provision is in the city charters and cannot be changed, and in some instances it is better without legislative approval. The sentiment is rapidly developing in the State toward having the charters revised, so that city physicians can be abandoned and medical service given by employing the family physician. In most instances, he is employed at his regular fees. Sometimes there is a reduction of fee but we have no State fee schedule. Some Counties are adopting such schedules in order to develop this work further.

In addition to these people who are dependent upon the public because of present financial conditions, and also in addition to the regular charity patients we have always had, we have also the problem of the old age pensioner. Such persons are cared for by the State and County on a 50% basis, and at present their medical service is provided in the same manner. The welfare officer, or representative of the pensioner, or representative of the department of social welfare, sees that the physician is employed, and is paid in that double way—50% by the County and 50% by the State.

We have, in addition, funds made available by the State through our Temporary Emergency Relief Administration. We have had several large bond issues, and have received some funds from the Federal Government. There are special administrative officers in every county for this purpose. They coöperate with the regular welfare officers, so that physicians are employed through the welfare officer and paid by him. He has an opportunity to be reimbursed in part for the money spent; 40% refund is available for home relief work. In providing medical services, recognizing the difference there naturally would be in fees charged and collected by physicians in different parts of the State, the Temporary Emergency Relief Administration developed an understanding with the welfare officers whereby the Administration refunds this 40% to the welfare officer on an arbitrary fee basis—$2.00 for a house call, $1.00 for an office visit, $25.00 for an obstetric case. The welfare officer is not expected to keep this basic fee as the entire fee to the physician. It is expected that he shall pay the physician's regular fee, but that the Temporary Emergency Relief will refund on the above basis of $2 or $1. That is difficult to explain; the idea behind it is the desire to establish a uniform basis throughout the State, so that one district would not get from the Temporary Emergency Relief a large sum of money while

another district would get a small sum for the same amount of service.

In rural districts, the matter of mileage immediately injected itself. The Temporary Emergency Relief Administration made no objection to the welfare officer paying mileage, but this must be paid out of his own funds. The Administration will not refund anything on mileage nor on hospitalization charges.

A committee appointed by Governor Roosevelt submitted a report just as he was retiring from office, which he referred to the Academy of Medicine for review. We took exception to his action because the Academy is a scientific body and not an organized society such as our medical body. Governor Lehman re-referred the matter to five physicians from the Academy and five from the State Society. These men are doing more than re-viewing that report; they are re-writing it and will probably have a report ready to submit by the end of this year. They are finding the matter exceedingly difficult, although the insurance companies are assisting with advice and data, in order that this committee may get a correct picture of the compensation problem. The insurance companies are aware, of course, of the fact that wildcat clinics have been a detriment to them as well as to the workmen. The Department of Labor is likewise sympathetic to the study.

There is a strong feeling on the part of labor that insurance of workmen should be carried by the State, and that there should be one fund, a State fund. We of the Medical Society are convinced that such would be a bad method and are using all of our influence to prevent such an idea gaining support, but unfortunately there are many physicians in the State Society who feel they would get better service if all insurance were carried by a State fund. We have a fund at present which is competing with the commercial insurance carriers and which carries a great deal of the insurance in the State. Some physicians claim that they get better coöperation from that fund than from commercial carriers, but I believe more physicians are dissatisfied with that method than are satisfied. However, I have no data on that score, and my impression may be a mistaken one.

Dr. Donald Guthrie, Sayre: In regard to the care of the indigent, as I understand it there is something about our charter in Pennsylvania that would prohibit adoption of any method like the so-called Iowa Plan, where each county commissioner, in arranging his budget, allows so much for care of the indigent. Each individual is scored up against the fund at the rate of $2.00 for medical care for the year, and then, out of this common fund, which is given over to the medical society, the services of the physician are *pro rata-ed.* I should like to ask Dr. Donaldson if he knows whether there is anything in Pennsylvania's charter that would prohibit any such scheme?

Dr. Donaldson: I think the charter prevents that. Such a contract would have to be signed by a group under control of the county society. Michigan had a law passed which permits a group of doctors to make a contract with a much smaller political division than a county society.

Dr. Guthrie: What plans have been suggested to carry the indigent?

Dr. Donaldson: That is a pretty big problem to inject in this discussion at the present time. Most of these men should be familiar with our Erie County plan, probably the most ambitious of all our county society plans. I would refer you to the April number of the Pennsylvania Medical Journal.

May I ask if there is any concerted opposition in New York State, on the part of carriers or employers or employees, to certain doctors, or if preference is shown for licensed industrial surgeons or organized industrial clinics rendering care beyond first aid, rather than for the private practitioner? Do they take the position that those who are insuring should be treated if possible only by a licensed industrial surgeon or clinic?

Dr. Lawrence: The sentiment among industries is, I believe, changing on that score. We have a recognized group of industrial surgeons, most of whom are men employed by self insurers. They have an organization that meets twice a year. They have met with us at our State Society annual meeting and they are all men of recognized ability. In addition, there are certain clinics that certain large industries have favored. One of those is the Wolfe Clinic in New York City—quite an extensive organization. At one time this clinic had more than 20 branch stations in the city. I do think, however, that industries are not partial to that way of doing business except, of course, that a large employer is more satisfied if the surgeon is the self insurer. The insurance companies, through an organization of their own, have had representatives in conference with representatives of the county societies of greater New York, and a gentleman's agreement has been arrived at under which they have been working for more than a year, recognizing the family physician even to the point of permitting him to do work without authorization, although it is required by law that authorization should be sought in advance. The county societies have contributed a good deal toward producing this form of safety by taking over a certain portion of censorship or interest in the fairness of the family physician's work and charges.

Dr. Donaldson: Do they take any interest in the quality of his services?

Dr. Lawrence: Yes. They have several times suggested that there might be a time in the near future when only experienced persons would be permitted to do industrial work, such as those who could be supported by the county society.

These Arbitration Boards that the county societies have set up in greater New York are composed of 2 members of the county society and 2 members from the insured company's organization as referees. Where any difficulty arises as to quality or cost of work, between company and physician, this matter is brought before the Board and ironed out. In the majority of instances the insurance company has given way, but in several instances physicians have been found at fault. One physician refused to abide by the decision and wanted to continue his work as before. That led to the question of whether the county society should discipline him. Of course, this Arbitration Board would have no jurisdiction over non-members of the society. I think, however, the insurance companies have been permitting those physicians the same privileges as members of the societies but I am not sure of that, because, after all, the insurance companies pay the commission to the one who has an interest in the case.

Dr. Morrison: We have similar commissions in New Jersey but there is no commission paid by the doctors. The only subject they discuss is the matter of the bill. If the insurance company considers that the bill is too large, it may be referred to this committee which is similar to the New York Committee, and the action of the committee is

final. Since those committees began to act about six or eight years ago, there have been practically no disputed bills presented. This method has been very satisfactory in its operation. The insurance company abides by the decision.

Dr. Lawrence: Dr. Guthrie spoke of the Iowa plan. We have in one county in New York a modification of this plan. Ontario County by agreement takes all of the relief work that is required. Family physicians are called upon, and they render service and file their bills. At the end of the year these bills are taken altogether, and each physician is paid *pro rata* from the amount apportioned by the Board of Supervisors for relief that year. Last year the physicians' bills were paid and each physician got about 16 cents on the dollar for the services he rendered. It was hoped that they might do better this year. I do not know that they will, because, while I think the budget is a little larger, medical relief service is growing rapidly and people are asking for much more than they did before.

One other matter I would like to mention is in regard to hospital dispensaries. We are making earnest efforts in New York State to solve this problem. In the last legislature 2 bills were introduced, which did not get farther than the committee, to prevent general hospitals or charity hospitals supported by public funds from charging for out-patient service. The contention was that any person who could pay for out-door service was not an honest charity patient. No general hospital should be prevented from rendering charity service to the indigent, but they should be prevented from rendering charity service to the partially indigent.

Buffalo has adopted a method on the order of the Cleveland plan, and Rochester has adopted what I consider a definite improvement over the Cleveland plan.

Prepayment of hospital services is being considered, although nothing definite has been worked out along that score.

Dr. Morrison: Your Suffolk County plan is much better than your Erie County plan, is it not?

Dr. Lawrence: They are different. Our Suffolk County plan is really a development of our general State program for county service. I refer to Erie County, New York, of course, and not Pennsylvania.

Dr. Morrison: One thing occurred in our State that may be of interest. Last year, the Board of Trustees of a certain hospital deliberately dismissed a member of the Staff (and Chief) who had been serving for 30 years. The entire Staff of 40 members resigned. Two or 3 doctors took care of the hospital but they were so crippled that the Board of Trustees was compelled to put in a Superintendent of our choice. We have now adopted a resolution that, when a Board dismisses the staff of a hospital, any doctor in the community who gives service to that hospital is subject to suspension of membership in the State Society until the matter can be discussed at a meeting of our Judicial Council, to which the Secretary of the County Society and the Board of Trustees have been invited. So we trust this sort of thing will be permanently terminated in New Jersey.

We have met the emergency relief condition in New Jersey somewhat along the lines outlined by Dr. Lawrence. We have 150,000 families receiving emergency relief. This means that the people who are receiving that relief are on a dole system in New Jersey. The medical profession was approached by the relief association and we agreed to furnish relief at about 2/3 of the fee usually charged in the communities where the service was given. It was left optional with the medical profession as to whether they would apply for mileage. Besides paying the physicians, patients are hospitalized at $3 a day. The number of people seeking relief in New Jersey is increasing constantly, and it is a most serious problem. The government is short of funds, and if it is not able to carry on this work in the future, a Panel System will probably be adopted. We are watching developments with a good deal of interest and much apprehension.

Dr. Donaldson: Was this proposal that you made to the Emergency Relief Association accepted?

Dr. Morrison: Yes, in every county.

Dr. Donaldson: Have you any idea how expensive it has been in counties where relief is most needed?

Dr. Morrison: I cannot state that. We have been operating only 2 months.

Dr. Lawrence: Did I understand that the Temporary Emergency Relief is paying hospital bills?

Dr. Morrison: Yes, $3 a day. We specified that they could terminate that relationship whenever they wished.

Dr. Reik: Dr. Morrison said that the relief plan had been operating only about 2 months, but he meant—under auspices of the State Society, for the relief work was originally begun in a few counties more than a year before. The reason for having the State take it over was because the excessive expenditures in some counties were exceeding the possibility of the relief administration to carry on, so, instead of making arrangements with individual county societies, the relief agency appealed to the State Society to handle it as a State-wide proposition.

Dr. Lawrence: Any physician rendering aid to a registered indigent individual receives $1.50 if his usual fee is $2?

Dr. Morrison: He receives $1 for an office visit and $2 for a house call.

Dr. Donaldson: Are you receiving Federal funds?

Dr. Morrison: Yes.

Dr. Lawrence: Doesn't the County Society have anything to do with the relief? Is it all done under supervision of the State Society?

Dr. Morrison: The State Society is coöperating with the County Societies.

Dr. Lawrence: Do you think that is a better plan?

Dr. Morrison: We think it is giving more immediate relief with concerted effort than if left to the individual county societies.

Sickness Service Echoes from the 1933 Session of the American Medical Association

Henry O. Reik, M.D.,
Atlantic City

Mr. Chairman: For once Dr .Reik has to beg your pardon for not having prepared something. He was drafted into service and felt like the man in Texas who, probably using orange juice under the Prohibition Law, swore that he could lick any man in that city. The observation was passed without comment, so he said he could lick any

man within the State of Texas; and, further, any man in the United States. And when he picked himself up from the floor, after that boast, he said: "I guess I tried to cover too much territory that last time." There was too much territory allotted to me in this matter. I was an individual member of the American Medical Association Meeting in Milwaukee. I was anxious to obtain information on this subject but found it exceedingly difficult to do so. I "sat in" at one session of the House of Delegates, and heard a number of resolutions presented and sent to some Reference Committee; but so far as I was aware, they were of an innocuous character and did not render much information that I could bring here as to the ultimate treatment by the organization of the Final Committee Report on the Costs of Medical Care, or of related matters.

In talking with individuals I found quite a variety of opinions as to what should be done in connection with any of these problems that we have been considering.

I do not know how many of you read Al Smith's address upon receipt of his Harvard degree, but it is worthy of attention. With his unusual ability for putting his finger on the vital thing, he referred to the most dangerous condition in this country at the present time "being" that of *"minority control"*. I think we could all profitably read his Harvard Address and ponder on its relationship to some of our medical problems.

Our State Society Committee's report is too long to be read here but it will appear in our Journal of September.

The Emergency Plan is a progressive step, but it is not going to be ended so easily as it appears here, of course. In view of what has been done under the name of *depression* for thousands of families in a state of inability to pay for medical attention, it appears possible that by the time it is concluded, 1,000,000 individuals in the State of New Jersey will have been aided. New Jersey has a population of only 4,000,000, and when Dr. Morrison says that 150,000 families are receiving financial aid at the present time, you can see how that cuts into the population rate.

Another point: In accepting this method of State-wide relief administration, we are taking a perfectly clear picture of so-called *state medicine*, and in some instances men who saw red at the use of these words nevertheless grasped *this* willingly and anxiously. We are faced by the fact that a very large number of people are coming under this relief administration of medical affairs at the present time. How long that will last we do not know. The fact that we have succeeded in putting into our acceptance of the plan a statement that the State Medical Society shall be the agent to determine when such matters shall come to an end, does not necessarily mean that they will have come to an end on that particular date, and I do not believe that they will. *I believe we are now taking care of thousands of people who will never go back to the private family physician and personal payment for medical service, after having had such a taste of State care.* The care is going to be quite as good and, as far as possible, through the same agencies. Is it likely that they will go back willingly, if at all, to the direct payment of fees to their family physicians? I think we have in that proposition the most advanced step that has been made to date toward acceptance of a form of so-called *state medicine*.

Pennsylvania Emergency Child Health Program

S. McC. Hamill, M.D.,

Philadelphia, Pa.

A few years ago there was organized in this country an Academy of Pediatrics. It now has a membership of almost 600. It was not created to compete with or to duplicate the services of already existing national pediatric societies. It is not just another clinical society. Its principal interest is in the preventive aspects of pediatrics. The Academy aims to function in large part through the medium of State committees, the purpose of which is to develop State-wide programs for the protection of the health of children.

The Pennsylvania Committee was organized in the early part of the present year. At its first meeting, called for the purpose of developing a program, it gave consideration to the procedures that had been adopted by corresponding committees in other States. After careful consideration it approved, with certain modifications, the plan that had been developed in New Jersey. This plan, which I understand was largely due to the vision and untiring energy of Dr. Stanley Nichols, of Asbury Park, called for creation of a State-wide committee under the auspices of the State Medical Society and having in its membership representatives from the State Departments of Health and Education.

The Pennsylvania Committee of the Academy, realizing that it was not numerically strong enough to put over a State-wide project, presented their program to the officers and trustees of the Medical Society of the State of Pennsylvania and ventured them to put it into action in Pennsylvania. While this recommendation was under consideration a situation arose which created an opportunity for an early response to this request. The Governor of Pennsylvania invited the writer to a conference in Harrisburg to consider the protection of the children of the State against destructive influences of the present depression. Pennsylvania was feeding 450,000 families at that time and in this number there were almost 1,000,000 children. All available evidence indicated that malnutrition was developing rapidly in this group as well as, and especially in, the children of the large number of families on the border-line of relief. The outlook for the future was uncertain and unpromising, and it was clearly evident that unless some well developed procedure was established for supervising the health of these children, there was promise of serious consequences to their future well-being.

It was decided at the Conference that, inasmuch as the subject to be dealt with pertained to the *health* of children, it should naturally be handled by the medical profession. To this end a small group, including the President, President-Elect and Secretary of the State Medical Society, met with the Governor to consider a plan of procedure.

The plan evolved called for appointment of a State-wide committee having in its membership representation from the State Medical Society, the State Dental Society and all outstanding privately supported agencies having to do with the health and welfare of children. It further provided for a medical chairman to be selected by the State Medical Society. All appointments to this committee were to be made by the Governor on recommendation of the President of the State Society, and the committee was to function under the auspices of the Society.

Two Advisory Committees were provided, one containing representatives from the Departments of Health, Education and Welfare, and the other to be made up of pediatricians to aid the chairman in preparation of health examination forms, selection of health literature, etc., and to advise respecting educational procedures if an educational program seemed desirable. The plan further provided for county committees, with the same kind of representation, to be selected and administered by the county medical societies.

It was not intended that these committees should in any way duplicate the work of any existing agencies or institutions, but rather, that they should bring into coördination the efforts of the medical and dental professions and all publicly and privately supported agencies interested in the health and welfare of children, for the purpose of supervising and protecting the physical and mental health of Pennsylvania's children through the existing economic crisis. The entire procedure is on a voluntary basis. The only funds provided are for the traveling expenses of the Chairman and 2 Vice-Chairmen, secretarial work and general office expenses.

This plan was formulated in February of the present year. The State Committee was appointed promptly and it met in Harrisburg on March 2 and unanimously approved the plan above described. The work, owing to delay in securing funds, was not begun actively, however, until about March 29. Despite this fact, the Chairman and 2 Vice-Chairmen have visited to date more than ¾ of the county medical societies and placed the entire program before them. Every society thus far contacted, with 1 or 2 exceptions, has agreed to organize a committee and undertake the work. This is in large part due to the enthusiasm and whole-hearted support given the committee by the Officers and Councilors of the State Medical Society. In many instances the Councilors have made it a point to be present at the initial contacts with county societies, and they have given a vast deal of assistance in other ways.

Twenty-eight Chairmen of county committees have been definitely appointed by county societies and 5 have been suggested but not finally chosen. Fourteen counties have asked for examination forms. About 12 of these are actually at work. These results to date are so far beyond our expectations (although not our hopes), that we are greatly encouraged.

The usual organization of the county committees consists of a medical chairman appointed by the county society who, together with his colleagues, selects one or more lay vice-chairmen or women and a small planning committee. This committee in turn considers a tentative plan of organization and procedure given them by the State committee, adapts it to the special needs of the county, and selects the personnel of the general committee.

As the purpose of this movement is to protect the health of children, it necessarily involves health examinations. This constitutes the principal function of the county medical societies in this work. In order to make the examinations uniform and have them reveal a picture that will enable the physician to determine the health and nutrition status of the children examined, a brief health examination outline has been prepared by the Advisory Committee of Pediatricians and approved by the State Medical Society. The physicians volunteering for this service are recruited from the county society, and the places at, and hours during, which they desire to make their examinations are recorded.

To make this service as easy and expeditious as possible for the physician, the fully organized county committees are providing 1 or 2 volunteer assistants for each physician. These volunteers prepare the children for examination, weigh and measure them, fill in the brief history asked for, and record the findings of the physicians as they are dictated. They also see that the recommendations of the physicians are sent to county headquarters for action, and report back to him the disposition of the case. An additional very important function of the volunteers is to serve as motor messengers for the transfer of children from their homes to the physicians' offices or other designated places of examination. For these services the volunteers are given a course of training and are required to submit to regulations such as would be required of paid workers.

Preliminary to these examinations, the county committee determines the particular groups from which the children are to be brought for examination. In practically all counties where work has begun, the first group selected is that of the children on relief, although it is known that many of the children of families on the border-line of relief are suffering quite as much, if not more. It is easier to locate the children of families on relief and this enables the committees to get under way promptly.

Another function of the county committees is to locate and provide for the care and delivery of pregnant women in the families of the indigent. Lack of obstetric care has constituted a serious problem in some counties.

In order that each county may know something of its problems in terms of the status of the health of children and the needs of expectant mothers, we have urged the county committees to make as full a survey as possible to locate those in these groups who are in need of supervision.

The best way to make the work of a county committee successful is by choosing a well-qualified lay vice-chairman who has had experience in organization and administration. In one county, for instance, the vice-chairman visited practically every section of the county, and had her volunteers provided by the time the physicians were prepared to begin examinations. Such a vice-chairman, by studying the problem and organizing the committee effectively, can relieve the chairman of practically all detail work, and of this there is a vast amount: selection of headquarters, locating and selecting and training volunteers, assigning them to the various services and seeing to it that they function effectively. She will also plan for the education of mothers in the families on relief as to the best methods of using the foods apportioned them by the Relief Board where commissaries exist, or in teaching them how to expend money doles or restricted budgets in such way as to secure nutritious foods at small cost.

In every county 3 groups have volunteered for such educational procedures—home demonstration agents, home economics teachers and dieticians. They are being used effectively in giving food demonstrations to groups of mothers. They show mothers how to prepare the food assigned them in palatable form, and how to divide it so as to secure a balanced diet and a distribution that will cover the period of days the food is supposed to last. This constitutes an important group who can be of great aid to the county committees in giving valuable instruction on nutrition in the schools

and to all groups the committee may wish to have broadly informed on the subject.

There are approximately 10,000 unemployed nurses in Pennsylvania at the present time, and the nurses' associations have said that they would be available for volunteer work and have provided their names and addresses for each of the counties. These nurses will be serviceable as physicians' aides, and it should be the function of the county committee to bring them into service and to assign them in so far as possible as aides to the physicians who are making examinations.

We are confronting many problems in the course of this work and some of them at times seem insurmountable. In order to reduce the number of examinations, we are suggesting to the county committees that examinations be not repeated where there is evidence that children have been carefully examined recently—as in schools of first, second or third class—at least until all other groups have been examined. But, as we are undertaking supervision of the health of children, it is important that the county committees endeavor in so far as possible to keep in constant touch with the child situation, so that serious mishaps may not develop unobserved.

We realize also that it is extremely important at all times, but especially in times of stress, that the children of the well-to-do and rich should receive health examinations. The present economic crisis has spared none of us. Every family is feeling its influence. This, with the grave uncertainty of the future, has created within every family an atmosphere of depression, tenseness and irritability. These manifestations are reacting unfavorably on the mental and physical health of children. Psychiatrists especially interested in children's work tell me that they are meeting with just such problems. For this reason we are urging the county committees to lay special stress on the importance of health examinations for all children.

The most neglected age group is that between birth and the sixth year—the so-called pre-school group. We have been unable to get much information regarding the status of the nutrition of this group. We are therefore urging that these children be given special consideration.

The exhaustive studies of the White House Conference revealed the fact that a very small percentage of the children in this pre-school group have been vaccinated or given toxin-antitoxin. We are therefore asking the examining physicians to list these cases, in the hope that they may ultimately receive this necessary protection.

The most serious problem we have to confront is provision for removal of adenoids and tonsils. Even in normal times this constitutes a problem. For this reason we are urging that only such cases as may fall within the emergency group be referred for operation.

Our next most serious problem is correction of dental defects. Everyone knows the extent to which dental caries has developed among American children. This means much curative work and the establishment of intelligent preventive procedures which are closely related to diet. The dental profession is coöperating most encouragingly, and in some counties the dentists have volunteered to take care of emergency cases in their offices.

The correction of eye defects is also serious but, fortunately, the number is relatively small. We are urging the county committees to develop some kind of service that will care for the more serious cases.

The building-up of the under-nourished, where this is due to lack of food, is simpler. Most of the County Emergency Relief Boards will provide extra foods for such children on the physician's recommendation. Those who do not respond to dietary treatment require further medical study.

I have drawn the picture of a formidable undertaking. No worth-while job is easy. We have advanced far enough, however, to prove that this job can be carried out effectively provided a large enough county committee is carefully selected and a large enough volunteer force is brought into action.

Let us consider just what this whole program means to the medical profession.

In so far as I know, this is the first time in this country that organized medicine has been invited to head up and direct a great emergency movement. The common procedure has been to have such activities organized and directed by lay persons. When medical problems arose, urgent appeal was made to the first physician available to aid in their solution. Fortunately, Governor Pinchot saw the wisdom of placing the responsibility in the hands of the State Medical Society. In doing this, he has given the medical profession what I believe is the greatest opportunity it has ever had to show what it can accomplish in a great undertaking to supply a serious health need in a time of crisis.

It has done vastly more than this, however. It has enabled us to establish the principle of medical leadership in health matters. Indeed, it is the hope of the officers of the State Society that this emergency committee may continue in a modified form as a permanent organization after the present crisis has passed, so that at all times the health activities of the county will remain under medical leadership and supervision. This will enable us to eliminate certain abuses that have at times arisen in non-medically guided activities, and better to coördinate the services of these agencies, which will result in better health service to the community. It will prove a great step forward in establishing the principle of periodic health examinations.

The trend in medical procedure the world over is in the direction of protecting the health of the individual instead of devoting our sole energies to trying to cure him after he has become ill. For our own financial protection it is essential that we encourage this practice. The public is being educated rapidly to the advantages of prevention and, as Dr. Vaughan has aptly pointed out, but 2% of the population are ill at any one time and 98% need to be kept in health.

There is one more point to which I wish to refer. For some years we have been fearing the socialization of medicine. It is my firm belief that if we meet effectively this obligation, we will have taken a long step away from social medicine. We will have brought the medical situation under our own control, and we will have established in the public mind a faith in and reliance upon us that they have not accorded us for a long time.

Dr. Lawrence: Does your State Department have a Bureau of Child Welfare?

Dr. Hamill: Yes.

Dr. Lawrence: Does it hold well-baby clinics?

Dr. Hamill: It does.

Dr. Lawrence: Does your organization now cooperate with them?

Dr. Hamill: It does. At the present time they are conducting, at the request of the relief board, extensive examinations in certain sections where commissaries have been established to determine

the effect of commissary feeding upon children. They are examining 1000 children in each of these areas. They will not go into any county to make such examinations unless they first get the co-operation of the county medical society, and they are using the same examination form that we are using in State work.

Dr. Morrison: Are you receiving financial assistance from any source whatever?

Dr. Hamill: Only for the traveling expenses of myself and 2 vice-chairmen. We have adopted the principle of going directly to the County Society to discuss these problems. We also get stationery and other office expenses for secretarial work. No salaries are paid except to secretaries. We have not been as fortunate as you were. We have attempted to secure some financial support for the physicians, and went to Washington to discuss the matter with the Reconstruction Finance Corporation, but we were turned down.

Dr. Lawrence: Do I understand that you get your funds through the Temporary Emergency Relief, which is a different organization?

Dr. Hamill: Yes.

Dr. Lawrence: Isn't that part of the Federal Relief?

Dr. Hamill: It is, but they approved no funds for drugs or physicians' fees.

Dr. Lawrence: You are not limiting yourself to the pre-school child, are you?

Dr. Hamill: No, but we have been able to get some information regarding the studies of nutrition in the school child through the medium of school examinations. In all but 17 counties there was evidence of marked increase of malnutrition among the school children. The only evidence we have of the pre-school child is through the State relief care which examined 10,000 children last year, and during 1930 and 1931 there was no change in the nutritional status of the children, but in 1932 it rose about 15%. That was a study dealing solely with the pre-school group. I have written to New York but could get no information.

Dr. Lawrence: We have been trying to encourage such study as an activity of the private physician. Do you examine the county clinics by the cards of the members of the county medical societies?

Dr. Hamill: Yes. They examine only indigents at the clinics.

Dr. Guthrie: Are not the children of the well-to-do brought to the clinics?

Dr. Hamill: No, they are not.

Dr. Lawrence: I would like to interject an observation at this point, in regard to the services that we are extending to the people at the present time, a differentiation from the service that was extended to indigent people generally in the past. In New York State, as in the other States, they have appropriated State funds for assisting these temporarily indigent people. These funds are different from the ordinary appropriations made in preceding years.

Dr. Donaldson: They were what we ordinarily called paupers.

Dr. Lawrence: Yes. I was discussing in Madison County the other day this question of temporary medical service and that county society said that they had gone on record again as being ready to provide all medical services that were needed by the people of that county whether they could pay or not. Those who could pay for services would do so and the others would be as certain to get service as those who could pay. They had not asked the State to compensate them for these services where the patients could not pay for them. I thought that was making a mistake.

Heretofore, we have always considered the indigent as our private charity. We have extended our services according to the Hippocratic oath to the indigent, but there is a group now between the indigent and those capable of paying for their services who are self-respecting and who up until this period were self-supporting, contributing citizens of our several States. They paid taxes and did all of the functions of a supporting citizen. At present, owing to the economic depression, they cannot do that. The funds supplied by the State in this emergency are, in my opinion, supplied for the purpose of helping those citizens maintain their respectability, and take the stand that they have suddenly gotten into this position through no fault of their own. For that reason I think the physicians should not contribute services but should help the State maintain the standard of that family and the State should pay him for his service through the funds appropriated for that purpose.

Dr. Donaldson: Is the State also paying for food for the group referred to?

Dr. Lawrence: Yes, for food, rent, clothing and medical service. These people are registered under the relief organization.

Dr. Hamill: Are the doctors being paid in this way?

Dr. Lawrence: Yes. There are some individual physicians who continue to give their services free, but the policy of the State is to pay.

Dr. Hamill: That would constitute a large problem in the State of Pennsylvania because a large percentage of people now on relief are self-respecting citizens who have met an unfortunate situation in which they must appeal for alms.

Dr. Lawrence: They do not want to accept this service and have these bills confronting them to be paid later, and if they are not paid, they cannot help but feel that the doctor has paid their bills for them. If, on the other hand, the physician makes his charge and it is paid by the State fund, the patient will feel that that obligation is discharged by the State for him.

Dr. Reik: We must not lose sight of the fact that under this proposition the profession is abandoning charity to glory in its charity service. However, when this subject was discussed recently in New Jersey that point was mentioned in only one County and they decided that they would take care of all such charity work but would not accept fees for their services.

Dr. Lawrence: Look at the embarrassing situation. Suppose realtors said that they would not charge rent at the present time; suppose the clothing stores would say the same thing? Would a man then, after he had accepted those services several times, ever regain his respectability? Why should not we physicians be exactly as consistent as others?

Dr. Morrison: We have several instances where people have been under the relief fund, and after the husbands secured work, they have offered to pay for relief given.

Dr. Reik: But those are a few instances out of thousands of persons treated.

Dr. Falkowsky: How is the respectability of these citizens judged?

Dr. Lawrence: The persons in charge of the welfare work are responsible. And that brings me to another point.

In our State, if a person is in need of medical service and cannot pay for it, he may apply to the physician residing nearby, and the physician may

render that service, or he may ask the welfare officer to authorize the service that he renders in order that he may be sure to get his pay; but the welfare people see that the proper procedure is taken, that the prospective patient makes application to the welfare officer for medical service just as it applies that authorization for food and clothing. The patient then really becomes a ward of the welfare officer, who was elected to take care of these people, not the physician. The welfare officer employs the physician.

Dr. Donaldson: Our Board of Trustees has taken the position from the very first that all of our members would, of course, gladly take care of those who had formerly been their patients on any deferred payment plan, or any other plan satisfactory to both. We have also requested all members of the County Societies to render all the aid they are called upon to give by emergency relief cards, differentiating from aid that should be rendered and could be reasonably expected to be rendered by physicians who are paid a salary. We have made no effort, but in fact have resisted pressure from some societies to proceed with the plan adopted in New Jersey recently. Your plan cannot be adopted in Pennsylvania because we do not have State laws to permit it. It will be interesting to see how long it will be before we in Pennsylvania must do as you have done in New Jersey, or to see if the matter will adjust itself in another way and we may stand in a different light to the State from what you do when this is all over. We have had editorial comments recommending that monuments be erected to physicians of the State for their work during this emergency.

Dr. Buyers: One point was brought up which I think we should differentiate from other things. There are certain counties in Pennsylvania that employ physicians for the poor at a given salary. They discriminate between the county indigent and the temporarily unemployed. The county indigent are taken care of by the Poor Board and the Poor Doctors under contract. The doctors will have nothing to do with the temporarily unemployed as they are not paid for that work at all, but they do take care of the indigent. The temporarily unemployed are cared for by the R. F. C. and, of course, by the physicians of the county society. There is some dissension there between the county doctors and the R. F. C. in selecting these cases.

The head of our R. F. C. in Montgomery County, who is a Judge, has laid down a definite definition drawing the line between the county indigent and the temporarily unemployed. On the basis of that opinion we have disseminated our work between the 2 groups of those entitled to medical care.

I would like to ask the difference between the T. E. R. and the R. F. C.? Dr. Lawrence has said that some of the money is Federal money. That must come from the R. F. C. Can that Federal money be used to pay physicians?

Dr. Lawrence: I presume so. I think the T. E. R. is a local affair but it is using Federal funds to a certain extent, I know.

Dr. Hamill: The rest is appropriated by the State?

Dr. Falkowsky: Yes. It comes from the R. F. C. through the Emergency Relief.

Dr. Morrison: The State Government in New Jersey is carrying our temporary relief control.

Dr. Buyers: I think Dr. Hamill divided the children into 3 classes, those that were able to pay full fees, those able to pay partial fees, and the indigent.

Dr. Hamill: That is correct. We considered the advisability of preparing a statement, to be given out by the State Society, somewhat similar to the one that was prepared for the toxin-antitoxin campaign in New York State. You will remember the card that was issued to physicians dealing with the subject of health examination, advising physicians to recommend to their patients health examinations for those who could afford to pay. I would like to get a reaction from this group to that suggestion, because we have hesitated to proceed with it. It was endorsed by the county medical societies and by the Health Department in New York.

Dr. Lawrence: The State used a card for the toxin-antitoxin campaign, but for examination of pre-school children or children entering school for the first time, they have used cards in New York City for that purpose. The doctors have had the cards in their offices and have put them where they would be observed effectively by the family.

Dr. Hamill: We are already getting reactions from people who can afford to pay, asking for health examinations.

Dr. Falkowsky: I think that will inspire a good many people who can afford to pay to have this work done, and therefore the doctor will be repaid eventually.

Dr. Lawrence: There is one fly in the ointment in our State, and that is, that the physician may not be conscientious in making his examinations. Our Public Relations Committee sent a letter out this last year to all school examiners and school physicians generally, urging that they take a greater interest in examining school children. We tried to emphasize the advantage to the physician, when doing this work conscientiously, in developing a future patient for annual examinations. You know, there are some physicians who will say to the patient, "I have known you all along. I have something else on hand just at present. Come back some other time. You are all right." Often they do the same thing with these children. Our school authorities have a blank which is quite large. The New York school authorities have a smaller blank with about 10 questions on it. I wonder which one is going to give the better service. I am watching our physicians up-State to see whether they are going to take the time to fill this blank out.

Dr. Hamill: We have endeavored to indicate on the blank the things to be looked for, with the idea that the volunteer assistants can simply fill in quickly by dictation. As a matter of fact, we have tested this out and it takes just 15 minutes to fill out the blank, provided the physician has an assistant, the volunteer aid filling in the first part and the brief history. Then on the reverse side of the sheet is space for a special nutrition examination, which includes the height and weight, and which the volunteer aid fills in. The remainder is filled in according to the dictation of the physician and does not take much time.

One object we had in formulating this kind of outline was to make it educational, because we believe that the future of medical practice should be among those who want to be kept in health, and we have tried to indicate what would be a minimal health examination. That is enough information upon which to pass a statement as to the status of the health of a child.

Dr. Lawrence: I heartily subscribe to that educational feature.

Review of Report of the Committee on Survey of Medical Services and Health Agencies to the House of Delegates, Michigan State Medical Society

Walter F. Donaldson, M.D.,

Pittsburgh, Pa.

In the excellence of the recently published report of the Committee on Survey of Medical Services and Health Agencies in the State of Michigan, as conducted by our sister State Medical Society—Michigan—I find my justification for the presentation to you today of this all too brief and inadequate review. The Michigan State Medical Society displayed wisdom, when, in connection with this elaborate piece of work, it recognized the axiom that the solution of a problem must be preceded by a clear understanding of the nature of the problem. We also extol the sagacity and enterprise of this State Society in undertaking its prolonged and expensive study, through a committee of its members, guided by that expert student of social evolution as applied to health problems in Europe and America, Nathan Sinai, Doctor of Public Health, of Ann Arbor, Michigan.

Before proceeding to phases of the study peculiar to the State of Michigan, the Report devotes several pages to a consideration of the evolution of medical care; and while this reviewer will quote but little from this chapter, he recommends it to careful students because it embodies in a series of terse statements and graphic charts not only its own observations but those of 4 widely recognized, recently published studies on modern economic society and its relation to medicine. The first chapter describes recent developments in medicine as "explosive in character", appearing "as a revolution within a revolution; the reverberations of the medical revolution" being "muffled by the louder rumblings in industry". A profound effect is said to have been exerted both on the training and the practice of the physician by the impulse of research said to be equal to the motivating impulse in industrial development described as mechanical horse power.

Reference is also made to a situation in medicine, analogous to technological unemployment in industry, this form of unemployment, or lessened employment, being said to have its origin in the advances of science. Michigan is presenting typical examples of this form of unemployment in medicine by its marvelous reduction in combined deaths from typhoid fever, diphtheria, tuberculosis, diarrhea and enteritis. Pointing out that had the death rate from the aforesaid in 1900 persisted in 1931, the total number of deaths from same would have been, in round numbers, 27,000 instead of 8500. The reduction in the number of cases that would have been treated by physicians in 1931, had the conditions of 1900 persisted, being expressed in the figures of 37,000 as against 8000. Describing this decrease as "one of the most amazing and probably the most gratifying of the results attained by modern medicine", the Report asks the question: "What new forms of employment are to be developed?" and proceeds to demonstrate that "the day is as yet far distant when the frontiers in medicine will be a thing of the past". Stating that "the right of progress in the 3 aspects of medical care—research, education and practice—have not been devoid of conflict", which now resolves itself into action "between those who say 'Let well enough alone', and those to whom 'well enough' is not good enough, the Report classifies this struggle as one 'between imagination and established habit' ".

Concluding that innovations and progress are not synonymous; that medical practice can no more maintain the *status quo* than any other movement in human affairs; and that attempt at such maintenance is a "symptom of rigidity" and a "sign of decadence"; and recognizing the impossibility of an immediate and complete solution of all medical problems, the Report then proceeds in detail to take the first steps toward settlement of such problems which, though complicated by a delay of half a century, offers the greatest reward in planning for the immediate future.

In succeeding chapters the problems within the State of Michigan are taken up from the following angles: "geographic variations, population distributions, incomes and costs of living, distribution of medical services and allocations of expenditures for these services".

The one outstanding physical characteristic of the State of Michigan is that it is almost entirely surrounded by inland water, which of course affects peculiarly its own climate, economic and social interests. Furthermore, on account of its double peninsular form, it lacks the sectional unity usually found in more compact areas.

The Report, pointing out that "this handicap is offset by the extent of its shoreline contact with many sections having various natural resources, and from which the State receives industrial stimulus", compares Michigan in this respect with England, an area of about the same size. In common with our own States—New York, New Jersey, and Pennsylvania—Michigan has its "fruit belt", its farming areas where, in contrast with countries in Europe and the Orient, much profitable land is either uncultivated or worked far below its capacity, crops being raised haphazardly by necessity, rather than most effectively.

Furthermore, Michigan has had its lumbering industry, now in the not uncommon second stage of operating here and there where small areas remain standing after the first cut. Certain industries associated with the forests and dependent upon them are dying "with the removal of the timber". The furniture industry is no longer dependent upon Michigan products, and imports are replacing native woods for the paper pulp mills. Michigan's "mineral resources, which are all nationally significant—iron and copper—will for years to come furnish irregular occupation to many citizens who will also stabilize the population as part-time farmers".

"Detroit, the largest city in Michigan, naturally leads the State in the variety and number of its industries", and its population, like the population of all cities of a million or more, will find its greatest difficulty in economic re-adjustment, including that of the proper distribution of sickness service to individuals and families struggling for a "larger share of security and satisfaction in life".

In a chapter devoted to 'Population, Income and Costs of Living", attention is centered upon such as related to the people of Michigan alone. After stating that "the position of medical care in the scheme of living is anomalous" because occurring, as it does, as a basic need along with food, shelter, etc., the Report states it is so rarely a daily need that its "cost must be met *after* the other daily basic needs have been provided". This reviewer takes issue with the Report in its apparent rigidity of expression on this point, which he interprets as practically shutting off further discussion of the consideration by those frequently thought of as

self-supporting, as to the consideration of any provision in advance for meeting the inevitable items of sickness prevention, or the always threatening expenditures incident to sickness or injury.

Chapter 4, under the heading "Illness, Its Incidence, Care and Costs" is abstracted from publication No. 26 of the Committee on the Costs of Medical Care, and is therefore not peculiar to the people of Michigan, and is no doubt familiar to many of you.

Chapter 5, "Physicians: Distribution and Practice", once again returns to the State limits, and throughout places particular emphasis "upon the distribution of physicians in private practice". Questionnaires were mailed to all physicians thus listed by the Committee on Public Relations of the various county medical societies, with the exception of Wayne County, in which the City of Detroit is located and where a questionnaire was mailed to every second name on the list. The schedules were to be returned unsigned, but each recipient of a questionnaire also received a post card, which he was asked to return, stating that his schedule had been mailed. "While the card did not identify any particular schedule of questions, it made possible an analysis of the returns and a follow-up program to secure more complete returns". By follow-up activities on the part of the local committees, the schedule returns reached a volume approximating 50%, ample to merit an analysis.

Discarding the commonplace "optimum ratio" of physicians to population, the Report discusses variables of both factors, the first being the training of the physician, pointing out that a single physician in a rural area or a smaller community may not be trained to render all the necessary medical services to a group of people. "The existence of many such areas and communities in Michigan emphasizes the dangers of broad generalizations in either the statement or the solution of medical economic problems."

"Another variable factor of major character is the ability of people to purchase whatever they recognize as necessary medical care. It is this 'effective demand' that determines whether or not the physician may derive a satisfactory livelihood from the practice of medicine."

"A third item that must be given attention is the need, rather than the effective demand, of the population for medical services."

During the 31 years reviewed, it is shown that while the population of the State has more than doubled, the number of physicians has increased only about 25%. Compared with 1900, there were approximately 300 more people per physician in Michigan during 1931. Possibly an explanation may be found in a great increase of both population and physicians in the city of Detroit, although the ratio between population and physician here has increased from 427 in 1900 to 773 in 1931. From 1910 to 1920, while Wayne County (in which Detroit is located) was gaining 575 physicians, the rest of the State lost 596.

The Report does not present the figures "interpreted as the beginning of a definite movement of physicians toward the smaller communities". On the contrary, "changes in the number of physicians in Alpena and Mecosta, up-State counties, with a reduction of 50% in number, may be contrasted with an increase of 138% in Oakland County, in which the City of Pontiac, a well-known automobile manufacturing center, is located.

The Report in part neutralizes the effect of such changes by the usual references to the ability, on account of improved modes of transportation, of the physician to serve much larger geographic areas.

Excluding from its estimates of physicians employed on a full-time basis, those retired, and those serving internships, and including all areas of the State, it is discovered that the "average population per physician in private practice, exclusive of Wayne County, is 1050; while that of Wayne County is 908". Table 26 of the Report discloses the following rather significant fact: that Wayne County, occupying less than 1% of the geographic area of the State but having 40% of the population of the State, nevertheless has more than 50% of the State's total number of physicians.

Surely these figures indicate the considerable portion of the population of the City of Detroit who must be receiving their medical service under some form of contract practice.

Referring to the figures published by the Commission on Medical Education, based on the ratio of 1200 people per physician, many counties in Michigan have more than 1200 people per physician, and certain others have less. Assuming that this standard is based upon the *effective demand* of the people for medical care, the Michigan Report refers to other studies, where it is set forth that to meet the *actual needs* of the population, it would require one physician to approximately 700 people, pointing out that on this basis there are too few physicians in private practice in every county in Michigan, except the county in which is located the State University.

It is evident, therefore, that over-supply or under-supply depends upon the standard adopted, and we must agree with this committee when it states, "The problem before the profession is to devise means whereby the provision of medical care may more closely approach the actual needs of the people", and also agree that "it will be a long time *before the public itself recognizes* all the fundamental needs; yet it is maintained that even now, through better distribution of service, a ratio of one physician to 900 people would not be unreasonable. Using this ratio as a unit of measurement, many counties now present distinct problems of under-supply. In nearly all others the aim should be to *increase the use of the physician's time* devoted to medical practice, rather than *to hope for a decrease* in the number of physicians".

The Committee discovered that in different parts of the State physicians have contractural relations, exclusive of insurance employment, differing from 10% of the total number of physicians in the City of Detroit to 27% in other areas. Their findings show that few physicians in Michigan are making annual physical or health examinations, in spite of the great publicity given to the project; and as further proof that the *public is not purchasing* preventive medical services, whatever may be the cause or causes, refer to the fact that "out of 100 physicians who had attended 100 births, only 4 reported a total of 4 diphtheria immunizations at the end of a year".

The Committee, in its analysis of the schedules returned by private practitioners regarding post-graduate education, consider "the figures disturbing, particularly as they concern the general practitioner. In none of the groups shown in the most populous part of the State do as many as 50% of these physicians report post-graduate study within the 10-year period. From 65 to 86% of the 'partial specialists' report post-graduate study".

In a chapter devoted to "Physicians' Income", an attempt is made to correct errors arising from

incomplete returns, and "1289 physicians submitted schedules which carried sufficient information about income to merit analysis". By a method of "weighting", according to type of practice, the costs of physicians' services during 1931 are presented for the State and the different areas in the State. Furthermore, each local sub-committee was asked to estimate within very broad income classes the probable incomes of physicians who failed to reply.

During 1931 the people of Michigan expended a total of $31,000,000 for the services of 4725 physicians in private practice; per capita expenditure for physicians' services amounted to $6.27; in one area the average was $4.22; in another, $7.20. Of this total, 3047 general practitioners received $16,400,000; 906 partial specialists, $7,231,000; 772 complete specialists, $7,510,000. The average gross income of the physician in private practice is $6590.

"Although the total gross expenditures for the State and the gross incomes of physicians show the amount of money spent by the public, it is the net income which primarily interests the physicians. It is this income that determines what amount of money the physician may expend for the needs and comforts of his family and for security during his old age. The average net income for all physicians is $3876. This amount is 59% of the gross income. Hence, the average expense of practice is 41% of the gross income. According to the median figures, the net incomes of ½ of all physicians in private practice are below $3264, and ½ are above this sum."

"One might say that an average annual cost to the family of $108.14 for medical care is evidence that no particular economic problem exists in the distribution of medical care. One might say with equal assurance that an average net income, in 1931, of almost $3900 per physician is evidence that the economic problems of physicians are largely imaginary. Chapter IV brought out the fact that the statement concerning families would not hold when submitted to a detailed and critical analysis. The same is true of the statement concerning the income of the physician. Most of the controversy that arises from these statements takes its source from a lack of understanding, appreciation, and willingness to give thought to anything but the gross picture of both costs and incomes."

"In Chapter III it was shown that 92% of the population divided 65% of the State's income. While this disproportion is found to no such extent in medicine, the figures for partial and complete specialists show that it exists."

"The lack of uniformity in physicians' incomes apparently arises from the 2 main causes, aside from those that may operate in the practice of an individual physician. These causes are: first, type of practice; and, second, size of community."

"Few will disagree that a physician's income below $2500 falls short of adequacy. Based upon this arbitrary dividing line, the results shown in Table 42 serve to emphasize the crisis in medicine. Two thousand seven, or 43% of the 4725 physicians in Michigan are required to maintain their standard of living on incomes of less than $2500."

"Almost ½ of the physicians in each type of practice are classed among those with adequate income."

"Undoubtedly many who read this report will conclude that this view of medical incomes is a distorted one. Who can say? There can be little doubt that incomes during 1932 were reduced still further, and that the downward curve is being extended through 1933. To say that incomes will return to the level of 1929 would be to make a brave, if not foolish, statement."

"Economically, the average practicing physician's position is not an enviable one. He enters private practice after a large outlay of capital funds at the age of 27 or 28; he must make a further outlay for costly equipment; and he must expect to spend 7 or 8 years in gaining the confidence of the community to the end that he may apply himself to practice for a reasonable portion of his time. The wonder is that so few physicians put aside the high code of professional ethics, and collapse under the economic pressure that so many suffer."

Passing from this very helpful and intelligent study of physicians' incomes to that of hospitals in the State of Michigan, we learn that hospitalization is there "very largely a governmental function, beds being government-owned to the extent of 54% of even the general hospitals". The Report attempts to decide the question, "Does a person living within 10 miles of a hospital enjoy hospital facilities?" And proves that nearly all the people live within 20 miles of such service; the question is asked also, "Should the same weight be given to the influence of a 100 bed-hospital as to a 10-bed hospital?" Of the 83 counties in the State of Michigan, 74 are below the State average for the number of hospital beds per people, which is one bed per 240 people. And as is no doubt true in many other States, it is discovered "that certain areas are provided with more beds than necessary", while "in other areas the number is entirely inadequate", indicating, so the Report states, "strongly the need for original planning in the original location and development of hospitals".

Exclusive of fixed charges, "the average cost per patient per day in 1931 for the State was $5.35". We will not discuss the problem presented to the physicians of Michigan by the "University of Michigan Hospital", except to say that being a teaching institution, with approximately 1183 beds, there has been at varying times much dissatisfaction on the part of private practitioners because of the treatment in the hospital by physicians, employed full-time as teachers, of patients coming from widely scattered points in the State, who are believed by private practitioners to be able to pay private physicians.

The objection raised by the State Medical Society to the present relations of the faculty are "classified simply into 3 groups: (1) Lack of consideration for the outside physician; (2) direct financial competition; and, (3) fear of State Medicine.

The Chapter devoted to "Public Health" begins with this sentence: "Civilization may be measured by the endeavors of man to conserve intangible wealth"; later stating, "While a century ago health was almost purely in the class of intangible wealth, today only the most backward individual or the socially retarded community would so regard it". The Report then calls attention to the generosity with which education and highway construction are supported in comparison with public health. Total appropriations by the State of Michigan to its Department of Health were $444,000 in 1924; in 1932, $456,000; while in 1915 the appropriation amounted to $32,000. The State Department is credited by the Report with placing "the emphasis upon activities leading to local organizations".

Michigan has a State law permitting the inhabitants of any township, by vote of its qualified electors, to grant money for the purpose of employing a public nurse or nurses for said township; but

the Report, after reciting certain "fundamentals of public health work", points to "how woefully inadequate is the work in townships and villages". The Report refers to arrangements in Wexford County whereby "a county board of supervisors pay a flat charge of $10 to local physicians for tonsillectomies, including a 24-hour period of hospitalization". There is also an arrangement with the local oculist to examine and provide glasses for children at a profit of $1 to the oculist. (What a contrast to the dignified professional standing of a true ophthalmologist.)

Without any attempt to discuss the various bureaus and their activities, except to agree with the Report of the Committee that the State of Michigan apparently presents the not uncommon state of affairs of "a striking multiplication of health officers and health organizations, which can mean only a diffusion of power and dilution of responsibility, and a loss to the State through failure to realize the full benefits of modern science", we proceed to the chapter of Miscellaneous Reports governing free clinics of various types and fixing for the City of Detroit, during the years 1931 and 1932, as "the average annual cost per patient, regardless of the professional visits made during the year, and including all types of service rendered, $5.76 and $6.59 respectively".

Pointing out that "these patients undoubtedly did receive services from other clinics, private practitioners, etc., and that the above figures would be increased", the Report adds the usual reference to the fact that "the figures on costs do not include any capital charges or remuneration to physicians". On the basis of $1 as the physician's contribution to the community for each visit made to them by patients in the clinics, $500,000 in free medical service was contributed during the year 1931 in the City of Detroit. This does not include services rendered to clinic patients confined in hospitals during that same year. "In 1931, approximately 18% of the population of Greater Detroit City sought medical aid in all the Detroit free and part-pay clinics".

The Report then deals with the Cancer Problem, Laboratories, the Medical Care of Negroes, the Problem of Tuberculosis, devoting a brief discussion to the Family Physician and the Control of Tuberculosis, which problem, the Report recommends, may be handled successfully only by "group plan headed by the organized medical profession, and a health agency provided with adequate financial support and personnel, with well-trained nurse-educators and public health teachers".

Under the sub-heading, "Care of the Indigent", there is a series of "arrangements for the care of the indigent, as reported to the Committee by various county medical societies". While there seem to be proportionately more of such reports than could be obtained from the county medical societies in Pennsylvania, and possibly from New Jersey, we note that the paragraph concludes with the following words: "In but few counties has the subject been approached in any other than a hit or miss manner."

Furthermore, the Report states that: "If the foregoing material concerning the care of indigents points to anything it is the need for much study concerning costs and a centralization of data so that it may be made available to all counties. It is apparent that there is less coördination of effort in the solution of this problem than any other in medical care. Antagonistic forces, bargaining, and like influences operate in the majority of counties to provide a service which is unsatisfactory both to the profession and the recipients."

In most of the 25 counties in Michigan from which reports were received, we note that county medical societies operating under a State law which permits contractural relations between groups of physicians and political sub-divisions, smaller than county units, are endeavoring to develop this type of group service to the indigent, to be paid for through Poor Commissioners, etc., which is in sharp contrast to the policy of the New York State Medical Society, which is endeavoring to discourage the development of such contracts for the care of the indigent sick, believing, as Secretary Lawrence recently stated in a letter to this reviewer: "The public would be better served if the work were done and paid for by case and call, rather than by contract."

In Chapter II, the Report is summarized and we note several paragraphs devoted to "Income: The Consumers of Medical Care", dividing the total population of Michigan—in 1929, 4,400,000—into 1,800,000 families and 76,000 unattached individuals as units—recipients of medical care—setting up as an intelligent basis of expenditures the following items in order of their importance: food, clothing, fuel, shelter, medical care, education, insurance, additional comforts, and then luxuries. The Report suggests that in the year 1929 the income of the people of Michigan having amounted to over $2600 per family of four, "this study could have been brought to a close at this point, with the conclusion that this sum is ample to provide subsistence, security and certain comforts". "This, however", it adds, "is the mass picture, and medical care is not being purchased on a mass basis. The needs are experienced and the purchases are made by individual families. Thirty-five per cent of the income was received by 8% of the population; therefore, the main interest centers about the 92% receiving the remainder."

Pointing out that while "in certain areas medical care must compete with insurance, transportation and certain other elementary requirements of the average family in 1929, the general income throughout the State was reduced 46% in 1931, with a decrease of only 17% in the costs of living" the Report proceeds to classify "as the most significant part of this study—*comparison* of the services received *and* the true needs for medical care", emphasizing that the "problem of medical costs arises not through the fault of the public or physicians, but exists because of the *variable* nature of illness".

The Report again takes the position that "medical care, with the exception of certain preventive services, is not a budgetable item"; reminds us "that many of the minor problems relating to the distribution of medical service have their origin in major problems and their causes"; and, "having the factual data as a whole", the summary concludes that "the major problems and programs facing the profession in Michigan are as follows:

(1) Continued study and preparation for meeting the immediate needs in the distribution of medical service,

(2) The distribution of the burden of costs to the end that adequate medical care may be provided for all of the people.

(3) A more equitable arrangement for the care of the indigent sick,

(4) The need for better distribution of medical facilities in the sparsely settled rural areas, and

(5) Wider distribution and a better coördination of public health activities."

Chapter 12 devoted to "Conclusions and Recommendations", describes as "a hopeful sign for the future the growing interest of the medical profession in economic problems", and classifies the entire Report with its data presented as "a contribution of the Michigan State Medical Society to public welfare". The Committee recommends that the House of Delegates appoint a standing Committee on Medical Economics, with broad powers to appoint sub-committees, and that each county medical society appoint a committee on medical economics, supplanting the present committee on public relations.

Health Insurance. After discussing principles of health insurance as it applies to the public and to the medical profession, the Report of the Committee reflects a position taken previously by the Director of its studies, and recommends that the House of Delegates approve the principle of health insurance, based upon the following policies:

(a) Free choice of physician by the insured,

(b) The limitation of benefits to those of medical service,

(c) The control of medical service benefits by the profession, and

(d) The exclusion of individuals or organizations that might engage in health insurance for profit.

Having thus disposed of sickness service to "workers of low average income who are unable to predict the time, severity or effects of serious illness", the Report makes recommendations regarding Medical Care of Indigents, epitomized by the reviewer as follows:

(1) Such care to be the joint responsibility of the community and the medical profession,
(2) Costs of medical care to be met through contributions of funds by the community and partial contribution of services by the profession,
(3) Compensation to physicians to be from community funds in proportion to the amount of service rendered,
(4) The community to centralize in one agency the social and economic appraisal of the individuals' or families' right to such medical service, and
(5) Local committees on medical economics, as well as the State Society Committee, to study and develop plans in accordance with the above.

Pointing out that it would "obviously be foolhardy for a physician to locate in certain parts of Michigan and expect adequate financial support from private practice alone", the Committee recommends to the House of Delegates approval of "the principle of subvention, through State or local funds, to assure reasonable and adequate medical care for citizens, and reasonable and adequate income and facilities for medical personnel".

Under "Public Health", the Committee recommends that every physician now theoretically so classified, should become in fact a public health official, recommending that the activities of "public health agencies should be concentrated upon *education* in two directions: first, of the medical profession to the end that it will be better able to provide the public's preventive medical needs; and second, education to the public to the end that it will seek preventive medical services". The Committee feels that this question is at this time secondary to items previously presented.

The final paragraphs read as follows: "The committee wishes to record its knowledge that the foregoing conclusions and recommendations constitute only the first steps toward the solution of medical problems. It feels that the Report has accomplished two things: first, a clarification of the problems in Michigan and, second, a declaration of certain broad principles upon which to build the future structure of medical service. If there is agreement among the members of the profession that these principles are sound, future progress should be rapid and effective.

"To paraphrase Salter, the committee has taken the system it knows, suggesting how it might be strengthened where it is weak, repaired where it has crumbled, and rebuilt where new needs require additions to its fabric. 'It is our own system in which we have grown up that we must reform—and in part transform.' " *

The reviewer, expressing again his great admiration for the enterprise of the Michigan State Medical Society in this pioneering endeavor, also appreciation of the intelligence of its scope and application, awaits with interest the reaction of the Michigan House of Delegates to the Committee's Report to be considered in special session in July. It is to be expected that debate will be earnest, introducing promptly emphasis on the paramount need for maintenance of good quality in sickness service, whether service be rendered in the grab-bag fashion peculiar to "lodge" medical practice, or in the more dignified relations obtaining under genuine private practice.

We believe that *now* is the time to completely discuss the truth as to the working interest of the general public in sickness prevention or service—infinitesimal in our opinion, except when illness or injury is imminent, or, if established, has become catastrophic. Now is the time also to declare frankly the trivial methods by which service is frequently delivered under European health insurance plans, before adoption by the States of this form of social legislation under the usual promising but almost totally misunderstood enthusiasm for a sociologic principle, which in its application often disappoints all but those whose satisfaction usually lies only in successfully promoting a particular type of social legislation.

With the clarifying influence of comments from representative physicians from all over the State, we are confident further study of Michigan's problem will proceed steadily toward a solution that will meet the entire State's actual sickness needs, and at the same time provide stimulating employment, with economic comfort, for the *able* and the *industrious* physicians of any section of the State.

Luncheon was served at 1.30 p. m.

Dr. Reik: I want to report that I have received a letter from Dr. Dougherty, Secretary of the Medical Society of New York, in which he says that the Executive Committee of that State Society recently voted to withdraw from the Tri-State Medical Conference. He does not give any reason, or state whether it is temporary or final. I wondered whether Dr. Lawrence would desire to say something on that matter before any action should be taken?

Dr. Lawrence: Gentlemen, I regret exceedingly the action taken by our Executive Committee and told them so at the time, but that did not influence their action. The action was unexpected, only a few present, and not given much consideration. Some one made a motion that the State of New York withdraw from this Conference, which was

*Salter, Sir Arthur, "Recovery, the Second Effort", The Century Co., New York, 1932, p. 334.

seconded and passed immediately. I started to advance arguments why we should not withdraw. They listened quietly and then without any argument voted for withdrawal.

Dr. Reik: In view of that explanation, we can only say that, unfortunately, New York State has not profited by our meetings as have New Jersey and Pennsylvania, due, I have always thought, to the fact that its Journal has not published the transactions of the Conference in full, nor in such manner as to be impressive; in consequence of which only a small number of the members of the New York State Society have had the remotest idea of what the Conference was about, and only knew that they were voting $150, possibly, *per annum* for this Conference, with never a report of what resulted from such expenditure. We attribute our benefits and gains to the very complete reports that have been published in the medical Journals of Pennsylvania and New Jersey.

Personally, I should hate to see the Conference discontinued. It has been highly beneficial to us in New Jersey. I would suggest that we simply express regret that the New York State Society's Executive Committee so acted, and the hope that sometime in the future the Society may feel inclined to again become affiliated with the Conference; and that, pending such time, New Jersey and Pennsylvania continue to hold these Conferences. Instead of 3 per year, we might perhaps have 2, or if that is not essential, only 1 a year, so that, at any rate, we may maintain the Conference. Perhaps I feel more strongly about it than others do, as this Conference is one of my children. During the first years of my work with the New Jersey Society I started several things, and perhaps this is one of the best things I did for New Jersey. I would be glad if Pennsylvania would express the sentiments of its members, as I do not want to appear to force any opinion.

Dr. Guthrie: I move that Pensylvania and New Jersey continue with this Conference and that the door be left open for New York State members to return at any future time it may deem fit.

Dr. Morrison seconded the motion and said: It is difficult to express appreciation of the activities of this Conference as found in my travels in connection with County Society meetings. All of our proceedings are published in full in the Journal and are thoroughly read by many of our members. Talking with County Society members, I find that they frequently refer to matters we have discussed. Representing as we do 25% of the population of America and 24% of the physicians, it would be a great pity if we ceased these Conferences. Dr. Olin West told me that with all the material coming to his desk every week, he never failed to read every word of this Conference. The outside is watching us. I am glad to hear Pennsylvania's support of the idea that we carry on and keep a light burning in the window for the wandering brother.

Upon vote, this motion was carried.

Dr. Lawrence: I know that I am speaking for quite a number of the men in our Society who have been closely associated with this Conference at one time or another during these years and who will regret, as I do, the action of our Executive Committee. When this action was taken by the Committee, there was but one man present who had ever attended any of these Conferences and that was Dr. Dougherty. You will recall the New York men who have attended the Conferences. Dr. Farmer was quite enthusiastic about them, and Dr. Sadlier most enthusiastic and he would have been here today had this action not been taken.

Dr. Morgan: I move that all former, present, or future officials of the State Medical Society of New York shall be extended a continuing invitation to attend our sessions at any time they may find it convenient to do so.

This was seconded by Dr. Albertson and, upon vote, duly carried.

Dr. Guthrie: I move that the resignation of New York from the Conference be accepted with regret. This was seconded and carried.

Dr. Reik: The next session of this Conference would be due in the Autumn, probably in the early part of November, to be held in the State of New Jersey, and I am taking the liberty of extending an invitation to meet with New Jersey as the host on that occasion.

Dr. Falkowsky: You have all heard Dr. Reik's invitation. I am sure all the men will be glad to accept this invitation.

Dr. Lawrence: One argument that I tried to advance to the Executive Committee was that the officers of 3 States so large as these, and representing, as they do, such a large portion of the American Medical Association, if they do nothing more than meet several times a year it would be quite worth while. When we had so many set papers, it was thought that the Conference was not accomplishing much, but our people in New York State never really got enough of the Conference to be influenced by the discussions.

Question: Do you think there is a possibility that New York may reconsider this?

Dr. Lawrence: Yes, I think so.

Dr. Reik: I would like to ask what specific action, if any, has been taken in the States of New York and Pennsylvania with reference to that much discussed final report of the Committee on the Costs of Medical Care? I saw a paragraph of resolutions that were up for consideration which seemed rather evasive. I have not been actually informed as to what happened in Pennsylvania.

Dr. Falkowsky: The only thing done was that we approved 100% the Minority Report. We sent out letters to all of the various scientific societies requesting them to defer action until such time as the real channels of medical organization were represented to the county societies and the American Medical Association would act upon it. We have had many volunteer workers and I think this has done more to popularize the Minority Report than anything else.

Dr. Reik: I have taken occasion to thank Dr. Donaldson personally for the "question and answer method" of discussing the Committee Report and the resolutions that accompanied it were good.

Dr. Lawrence: You will find that it took 2 issues to give all of our Booth Committee Report. We are with the Minority Report and specifically have shown why the report was not acceptable.

Dr. Morgan: At the recent meeting of the A. M. A., the House of Delegates adopted the Minority Report as the official opinion of the A. M. A.

Dr. Reik: In New Jersey it was in most places submitted to a special committee for consideration. The same sort of a situation arose as occurred nationally; we had at the Annual Meeting a *majority* and a *minority* report submitted. The matter was referred to a Reference Business Committee for consideration and they reported back that they had not found time to study it. Perhaps Dr. Morrison would like to finish the discussion of this subject.

Dr. Morrison: The Committee realized that they did not have time to give a matter of that scope

proper consideration and they reported that it will be amplified next year.

Dr. Hamill: Referring to the health examination form in connection with the Child Health Committee, we are sending out a brief explanatory statement, which I will pass around. This is to further increase the educational value of this movement.

Dr. Lawrence: May I personally express my appreciation of Pennsylvania's delightful entertainment.

The Chairman announced that one of the Trustees of the Pennsylvania State Society, Dr. Harry Mitchell, had died recently.

Adjournment at 2:30 p. m.

AMERICAN MEDICAL ASSOCIATION MILWAUKEE MEETING

June 12-16, 1933

(Through the courtesy of the Secretary and General Manager, Dr. Olin West, and the Editor, Dr. Fishbein, we have been supplied with the recorded and published [Jour. A. M. A., 100:2016-2023 and 101:39-54, June 24 and July 1, 1933] "Proceedings" of the recent Annual Convention of the American Medical Association, and accorded the privilege of reproducing in our State Society Journal all or such parts thereof as may seem of the greatest importance to our members. As the Medical Society of New Jersey holds the honor of furnishing the largest percentage of member-subscribers to the A. M. A. Journal—leading the entire galaxy of States with a record of 74%, while its nearest competitor reached only 67%—we may assume that it is unnecessary to give space to the "Proceedings" in their entirety, and will therefore limit this reprinting to a choice of those items which have a distinct bearing upon or relationship to matters with which our organization has been most concerned.—Ed.)

Address of the Speaker, Dr. F. C. Warnshuis

The thoughts and hopes of the medical profession of this nation are centered this week in this House of Delegates. Every County and State medical organization appeals earnestly and hopes trustfully that your deliberations and enactments will formulate policies and procedures that will be helpful in their attaining solutions of the local and individual problems that confront them. Every Delegate should deeply sense his obligations and clearly recognize the magnitude of the trust that is reposed in him as a member of this House, that must determine the policies of the Association. That responsibility is greater today than during former sessions.

This House is confronted by conditions created by epochal events in our national life. They may necessitate revision of attitude and intensified activity with increased alertness as to how best to enhance the vital interests of the public and the profession.

There is need for keen appraising judgment. The greatest acumen must be subpenaed in order that your final acts will well meet up to the demands of the times and continue to maintain the present high standards, functions and leadership of the Association. Emotionalism must not supplant judgment. The needs of the hour must not warp our vision or duty to the future. Your Speaker is confident that you will respond to the need of the times by recording action that will reflect mature deliberation characterized by constructive, guiding enactments.

It is desirable and essential that you secure every fact and obtain all possible information before final opinions are expressed.

(The last sentence above quoted is very gratifying to us because it constitutes a confirmation of the policy—if it may be so-called—we have been employing with regard to highly important problems of economics.—Ed.)

Address of the President, Dr. E. H. Cary

Medical Care for the Veterans. Your Legislative Committee has labored earnestly to meet the issue raised by the ever growing service to the Veterans which is the result of legislation in their interest. The question of hospitalization has been a serious one and, though there has been no desire to prevent the most liberal care on the part of the government for the service-connected disabilities due to the war, we have strenuously objected to the liberalization of laws which permit the man who is able to pay for medical service to enter veterans' hospitals for free medical care. We have objected to more hospitals being built unless they are needed to care for those suffering with tuberculosis or with mental and nervous disorders, or unless they are needed as old soldiers' homes.

Your President, with Dr. Woodward, appeared before the Joint Committee of the Senate and House. The opportunity was accorded us to present what we believed to be your point of view on this question. The committee manifested an increasing interest in our presentation. Many questions were asked and we both felt that the committee agreed in the main to the principles we supported. Undoubtedly, a widespread sentiment has been developed in Congress that our government has gone far enough in its hospitalization program. We believe that the status of this question is in harmony with your views. Since the advent of the new administration, we have been told that no more hospitals are to be built, even though the money has been appropriated; that some of the hospitals already built are to be closed, and that hospitals in process of construction and considered desirable will be finished and used. We were informed that the beds occupied by non-service-disabled veterans will be gradually assigned to those who are suffering with tuberculosis or nervous and mental diseases, while some of the hospitals are to be altered so that they can be used more and more for domiciliary care.

Following the adoption of the economy program of the President as to veterans' gratuities, an order was issued to the medical officers of the veterans' hospitals by General Hines, humane in tenor, stating that only those who were well or those who could be properly discharged from the hospitals be sent home. This order has resulted in about 15,000 patients being dismissed up to June 3, 1933. This is reflected in the cancellation of certain contracts with the Army and the Navy and in the reduction of personnel, physicians, nurses and other help, in many of the hospitals which remain open. There has been an effort made to reduce the occupancy of all beds heretofore used by the non-service-connected disabled soldier and, when this point has been reached, then the future use of the beds will come from a very numerous group of service-connected cases, many of which are now being cared for at home. In other words, the department intends to keep the present beds, totaling 41,000, in veterans' hospitals in service. The rebellion of the Senate and House, forcing a

compromise, may reopen many phases of the question.

We must not lose sight of the fact that the present program is also the result of a depleted treasury and, if the economic situation of the country should improve before the present policy is well established, the demands of the veterans having non-service-connected disabilities may re-establish abuses of governmental aid to which we have objected. Hence, it is necessary for members of our profession to continue their opposition; otherwise, we shall be confronted with the same situation as it existed before Congress gave its support to the request of the courageous President of our country.

Report of the Committee on the Costs of Medical Care

The *Minority Report* of this committee has been supported by the members of your official family and, though both the *Majority* and *Minority Reports* have been given wide circulation and thoroughly discussed, we feel that the great majority of the members of the medical profession throughout this country is supporting the *Minority Report,* both as to principles enunciated and as to the expediency of not determining a far-reaching policy affecting the medical profession at a time when the economic status of this country is abnormally low and likely to improve.

While cognizant of the demands made on the profession to readjust its methods and practices, we have protested that readjustments, if needed, should follow a full and complete discussion of all phases of the subject. We have believed that a solution can be found, through the coöperation of medical men who are deeply interested, that will not involve the destruction of fundamental values underlying medical practice. With this in view, the County Medical Societies have been encouraged to give serious study to the economic phases of the practice of medicine and to solve their problems, keeping in mind the fundamental principles underlying our ethical relations to one another and to the public.

We recognize the varying conditions and realize the impossibility of meeting this difficult situation with any one plan such as those that have been offered from various sources. Our organization is striving through its leaders at headquarters and elsewhere to serve the public and the profession of medicine, first, by discussion of problems; secondly, by trial of suggested plans; thirdly, by searching for and finding the truth, and thus be able to crystallize the professional mind so that unity will prevail. We all recognize that until there is unity of spirit and professional desire among the members of the County Medical Societies which are units of our organization, no plan, however far reaching and humanitarian in its aspects, can hope to live without the coöperation of the majority of men practicing in that locality.

Care of Sick Indigents. The attitude of society should be directed to its own responsibilities. It should either correct the causes leading to dependence or assume its burdens as related to the sick so that this demand on the profession is cared for by society and not expected from the doctors. This should be accomplished through the use of the members of the County Medical Society and the local health agency. It is essential to cultivate public opinion to develop an adjusted budget by the various communities to meet their local health requirements.

Indigence should not be encouraged but should be recognized as a part of the social deficiencies which are to be met from a general fund rather than the present plan, which lacks the advantage of a definite responsibility. It is undoubtedly to the advantage of society as well as to the indigents to establish more concretely the forces that lead to the best remedial care. When attempting to construct a plan in one's own mind, which might aid in the solution of the difficulties which arise to separate these 3 groups, we must consider the strength of these forces, which through training and experience are to coöperate. Their respective influence on their associates and society is important. With this in mind, we evidently turn to the most logical group whose purpose and ideals definitely harmonize and whose machinery is best adapted to make it the one great power which can be used for the common good.

My friends, wherein does this power lie? Is it not in and through organized medicine? Has not the health and happiness of the people always been dear to the men who have made and who sustain the American Medical Association?

A great community interest encourages the individual doctor and sharpens the competition for him because the people are free to choose the men who can retain and best use the information acquired. This is made possible for all the people because of the activity and orderly force created and kept alive by organized medicine.

The Journal is the greatest means we have for distributing quickly information; without it we should be helpless in quickly mobilizing professional opinion. Although it is true there are many members of the American Medical Association who do not take The Journal—and let it be said here that they are appreciated members through their County Medical Societies—yet it must be clear that only through subscribing to the greatest medical periodical on earth do they become contributing members. No other journal of national interest in any other land can be had for the price paid for The Journal. A reduction in the subscription price, if only $1 a year, would, the past year, have converted a net gain of the Association into a probable loss, thereby curtailing many of the valuable activities of the organization. Our organization cannot safely retrench at this point, for The Journal is worth more than it costs in money and the money is needed and used in the interest of its members.

Address of the President-Elect, Dr. Dean Lewis

Hospital Problems. One of the main problems which had a decided effect on the profession was the extensive hospitalization program which the government embarked on immediately following the war. The legislation that was passed is of such recent date that it is not necessary to review it. Non-service-connected disabilities entered largely into the program, so that finally almost 70% of the cases that were hospitalized presented disabilities which had nothing to do with the service and did not even have a presumptive connection. Ochronosis, acidosis, gout and obesity were even on the list of diseases and were applied in the rating of disabilities. In the economy program that has been attempted, non-service-connected disabilities were excluded. Recent happenings indicate that much pressure has been brought to bear and that hospitalization of non-service-connected disabilities may again be attempted. If the bars are let down, there will gradually be an increase in the amount of hospitalization and a return to the conditions

which existed before the attempt to economize was made.

There is no argument as to the responsibility of the government in the care of the service-connected disability, nor as to the responsibility of the government to the widows and orphans of those who were sacrificed in battle. But any man discharged from the army who is able to make his living has no lien on the government. This is generally admitted. It is much more difficult to rescind legislation than it is to prevent its passage. The medical profession must still make untiring and unceasing effort to prevent the hospitalization of non-service-connected disabilities. If such continues, the foundation of medicine and the future of medicine are threatened. Hospitals already built for the care of the civilians in different parts of the country cannot carry the financial load long.

The losses which hospitals have suffered have led some of them to accept different schemes, which they will be glad to cast off when the depression is over. You will hear that it has been found after a careful survey that there are more than 30 schemes which have been proposed to provide for the periodic prepayment purchase of hospital care. Some of these schemes are revolutionary in character. They are proposed and backed by propagandists and promoters who are looking for a profit. Beware of the promoters who are robed in the pure white of charity. No consideration is given to the relation between patient and physician. They have not confined their effort to the low income groups, and no attempt has been made to exclude from their scheme the final inclusive medical service with hospital care. In fact, in some of these schemes it is frankly stated that such is the ultimate aim.

The medical profession should take an active interest in hospitalization. Hospital planning should be undertaken. A city or town of 15,000 people should not have 3 hospitals. One good hospital could take care of the needs of such a community. Better have one hospital that is full and active than 3 partially filled. The partially filled hospital has an enormous overhead. Always expecting to be filled, it keeps a large civilian staff always expecting that it will suddenly be called on to work overtime.

Hospital construction has run riot. Many hospitals are built as memorials, and some are built to tickle the vanity of hospital achitects. This point has been emphasized so much that I need say nothing. One of the many increases in the cost of medical care has been hospitalization.

In some ways the depression has rendered a great service, as it has been demonstrated that many of the mechanical aids to practice are not necessary and that the cost of medical service may be greatly reduced and the quality maintained. Sir James Mackenzie stated the case well when he said, "It would be as ridiculous to put a man with a cut finger through such a process (a thorough examination) and expect him to pay for it, as it would be to expect an automobile owner to have the entire machine overhauled each time he has a puncture." Simplification of medical practice should be the aim of this organization. Such a simplification will mean a limitation of specialism and the reduction of specialists. A motion providing for the recognition and listing of specialists was passed last February before the Council on Medical Education and Hospitals.

When medical education was passing through such revolutionary changes a few years ago, state licensing boards formulated some stringent and restrictive rules which many of the poor schools could not meet and they were forced to close. With the improvements that have occurred in medical education, many of the requirements might be rescinded. Schools that are recognized as giving good courses should arrange their own schedules, determine the type of internship which they think best and the number of hours which should be devoted to a subject. Their aim and desire is to graduate the highest type of student, who should be admitted to practice when graduating from such a school without examinations before State Boards.

Certification of Specialists

Dr. Samuel J. Kopetzky presented the following resolutions:

Whereas the Council on Medical Education and Hospitals for something more than a quarter of a century has been engaged in formulating standards for the training of physicians, and through its policy of investigation and publication has succeeded in elevating the general standard of medical education throughout the country, and

Whereas in recent years the Council has, under the direction of the House of Delegates, in consultation with the leaders in these respective fields, established certain standards for the recognition of qualified physicians specializing in pathology and radiology, and

Whereas there is evidence of a widespread interest in the problems of medical specialism and a very general demand that means be found and standards formulated by which specialists may be known and recognized by their fellows in the profession, and that in this process of standardization there should be a national and uniform standard rather than a multiplicity of standards represented by the various state boards and state societies, and

Whereas a number of special examining boards have already been created to test the fitness and certify the qualifications of men engaged in, or desiring to engage in, special fields of practice, and such certificates have come to be regarded as establishing the skill and proficiency of those to whom they have been issued, and

Whereas the Council may contribute to the usefulness of these special examining boards by granting some form of recognition to those which now, or hereafter, maintain satisfactory standards of organization and procedure; therefore be it

Resolved that the Council on Medical Education and Hospitals is hereby authorized to coöperate with the existing examining boards (official) and the Association of American Medical Colleges, the Federation of State Licensing Boards, the National Board of Medical Examiners, through an advisory council hereafter to be set up; and be it further

Resolved that the Trustees and the Council on Medical Education and Hospitals be authorized to deal with the question of listing of specialists in future editions of the American Medical Directory as mutually agreed upon in the Advisory Council thus set up.

These resolutions were referred to the Reference Committee on Medical Education, and, after public hearings in which Dr. Fishbein representing the Trustees, Representatives of the Council on Medical Education, Representatives of the several National Examination Boards, and interested individuals participated, *the following resolutions*, presented as the Reference Committee's Report, were adopted:

Dr. Irvin Abell, Chairman, presented the following report:

The report of the Council on Medical Education and Hospitals displays a comprehensive grasp of the problems presented in these fields and the employment of constructive efforts to advance their solution. The resolution embodied in paragraph 2 of the report reading, "Resolved, that should the House of Delegates so order, the Council is prepared to extend to other special fields of medicine the service which it has rendered in the fields of radiology and pathology to the end that members of the medical profession and others who may be concerned may be able readily to distinguish those who have received training in the various branches of medicine from those who are merely self-constituted 'specialists'," is recommended for adoption.

Here followed the first 5 paragraphs of Dr. Kopetzky's resolutions, as quoted above, leading to these resolutions:

Resolved that the Council on Medical Education and Hospitals is hereby authorized to express its approval of such special examining boards as conform to the standards of administration formulated by the Council; and be it further

Resolved that the Board of Trustees of the American Medical Association be urged to use the machinery of the American Medical Association, including the publication of its Directory, in furthering the work of such examining boards as may be accredited by the Council.

Objectionable Radio Broadcasting

Dr. Moll, of Michigan, introduced a series of resolutions concerning this deplorable situation, which were sent to the Reference Committee on Public Health, and after hearings and due consideration they were, in an amended form, adopted as follows:

Whereas, Radio broadcasting is under the control of the Federal Radio Commission, and

Whereas, There appear to be no apparent restrictions of the advertising statements and claims that are being broadcast, and

Whereas, It appears that the radio is being employed to broadcast unsupportable claims and statements related to a large number of alleged preparations for the cure of many ailments and diseases, thereby misleading the public; therefore be it

Resolved, That the Board of Trustees, through the Bureau of Investigation, and through such other national organizations as the Board may be able to enlist, initiate and pursue activities and efforts to terminate misleading and misrepresenting radio broadcasting that is related to medicinal remedies and preparations for the conservation and protection of the health interests of the public.

Endorsement of the Minority Report of the Committee on the Costs of Medical Care

Dr. Henry C. Macatee, District of Columbia, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

Whereas, The Medical Society of the District of Columbia has endorsed the Minority Report of the Committee on the Costs of Medical Care, and has undertaken to engage in an intensive campaign to educate and inform its constituency regarding the socio-economic aspects of medical practice, with a view to the maintenance of high ethical standards and the preservation of professional ideals:

(a) By the dissemination of literature;

(b) By the organization of a speakers' bureau for the purpose of presenting various aspects of the subject to the membership;

(c) By the organization and conduct of study groups; and

(d) By the employment of such other means as may from time to time be deemed expedient for that purpose, and

Whereas, The Medical Society of the District of Columbia has by resolution instructed its delegate to endeavor to secure the support of the American Medical Association both of the Minority Report of the Committee on the Costs of Medical Care, and of the society's plan for promoting harmony of professional opinion and action on the socio-economic aspects of the practice of medicine;

Resolved, That the House of Delegates of the American Medical Association endorses the Minority Report of the Committee on the Costs of Medical Care as expressive, in principle, of the collective opinion of the medical profession; and, in order to clarify and harmonize the thinking of the individual members of the profession on the general subject of the said report, and on allied subjects.

Resolved, That the Board of Trustees be requested to undertake "the sponsorship, direction and active participation by the American Medical Association in an intensive campaign to be conducted in coöperation with its constituent bodies for the purpose and along the lines indicated" in the first paragraph of the preamble to this resolution.

The Report on this from the Reference Committee on Legislation and Public Relations, was as follows:

1. With reference to the resolution introduced by Dr. Henry C. Macatee, delegate from the Medical Society of the District of Columbia, your committee recommends that the House of Delegates commend the action of the Medical Society of the District of Columbia in informing its members of the medical and social implications of the Minority Report of the Committee on the Costs of Medical Care, in order to enable them better to support the principles and recommendations of that report. Your committee recommends that the House of Delegates commend this plan to the favorable consideration of other constituent associations.

Your committee believes that the organization of groups around hospitals or otherwise, supported by a voluntary or compulsory insurance or taxation, as recommended by the *Majority Report* of the Committee on Costs of Medical Care, would be inimical to the best interests of all concerned. It believes that such a plan, if compulsory, would encourage malingering, would create a vast political machine with all its evils, would inevitably lead to state medicine, and would reduce our profession to the status of government employees with the present relation of physician and patient a thing of the past. Your committee believes the Minority Report and its recommendations offer the best solution of the existing situation and the only hope for a future stabilized medical practice. It recommends that the House of Delegates adopt the resolution proposed by Dr. Macatee, namely:

Resolved, That the House of Delegates of the American Medical Association endorse the *Minority Report* of the Committee on the Costs of Medical Care as expressive, in principle, of the collective opinion of the medical profession.

Report of Reference Committee on Medical Economics

Dr. Arthur J. Bedell, Chairman, presented the following report:

Your committee has carefully reviewed the report as published in the Handbook and concurs with the Bureau that "the problems that presented themselves were not all the result of current social and economic conditions but were, in some instances, the culmination of long standing and gradually developing practices. The schemes which were promulgated in the guise of cures for certain alleged faults in the administration of medical service represent a rapid extension of commercialism into the provision of medical services."

Your committee appreciates the special consideration that has been given to contract practice and agrees that this type of medical work is constantly changing. It recommends that the study of contract practice be continued, and the action of county societies in dealing with these problems be based on the recommendations of the Judicial Council:

By the term "contract practice," as applied to medicine, is meant the carrying out of an agreement between a physician or a group of physicians as principals or agents and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or for a fixed rate per capita.

Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is a solicitation of patients, directly or indirectly. (2) When there is underbidding to secure contracts. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of his employment make it impossible to render adequate service to his patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect, for good or ill, on the people as a whole.

Group hospitalization has been described and criticized in several issues of the Journal. Certain phases of some plans may have merit. The committee believes many contain features which are subversive to the best interest of the public, the medical profession and the hospital, and it condemns any plan which incorporates principles contrary to the remarks on contract practice. The committee recommends that the investigation of group hospitalization be continued and that the results of the studies be published in the Medical Economics department of the Journal.

The provisions of most workmen's compensation laws have been a constant source of irritation and annoyance to employees, employers and the medical profession. The committee approves of the report, prepared by the Bureau, on Medical Relations under Workmen's Compensation and recommends that it form the basis of state conferences.

The committee looks with favor on the medical economics course in medical colleges but urges that only competent instructors be employed. It recommends that the outline on medical economics be completed by the Bureau and submitted to all medical schools who desire it.

Group practice has received widespread attention. The articles in the Journal have been comprehensive in scope and the facts presented well correlated and so authentic that they should form the basis for any consideration of the problem and be read by all members of the Association. Those forming a group should be guided by the same principles regarding professional qualifications for practice, ethical relations to fellow practitioners and consideration for the economic position of those whom they serve as should guide the individual practitioner.

The committee notes the conferences on health and accident insurance practice and recommends the approval of the proposed short form health and accident claim proof blanks. It senses in this newly developed relation between our Association and this service group opportunities for improvement in our mutual contacts.

The committee commends the Bureau's activities, the field investigations of the director and his assistant, the number of special engagements that have been filled and particularly the published analyses. All of these efforts have been excellent and command attention and the committee recommends that they be continued.

It is with a feeling of pride and a growing sense of security based on the information gathered and disseminated by this Bureau that the committee recommends the report as a whole to the House of Delegates and expresses its approval of the work done by the director and his assistant.

Arthur J. Bedell, Chairman
Walter F. Donaldson
C. W. Waggoner
Jabez N. Jackson

The various sections of the report were adopted on motions of Dr. Bedell, duly seconded and carried, after discussion by Dr. Holman Taylor, Texas, and by the Secretary, after which the report of the Committee was adopted as a whole.

Rules and Order of Business

(The Medical Society of New Jersey, we are pleased to report, was indirectly honored by the appointment of Dr. John F. Hagerty as Chairman of the important Reference Committee on Rules and Order of Business, and his Report, which follows, was unanimously approved.—Ed.)

Dr. John F. Hagerty, Chairman, presented the following report:

1. The committee endorses the resolutions that constituent associations elect their delegates far enough in advance so that the names of all delegates may be properly listed in the Handbook of the House of Delegates, and approves of the suggestion, where possible, that the terms of delegates run from January 1 to December 31 of the years for which they are elected. It also endorses the suggestion that copies of this resolution be sent to the secretaries of all constituent associations.

2. The committee also endorses the resolutions presented by the board of trustees of the Medical Society of the State of Pennsylvania and the council of the State Medical Society of Wisconsin, which are practically identical and which declare that all public opinions on general, social legislative and economic relationships of medical prac-

tice be made only through approved channels of the American Medical Association.

Respectfully submitted

John F. Hagerty, Chairman.

Dr. Hagerty moved the adoption of the first section of the report with respect to the election of delegates by constituent associations and the motion was seconded by Dr. William H. Myers, Georgia. The resolutions were referred back to the committee after discussion by the Secretary.

On motion of Dr. Hagerty, seconded by Dr. William R. Molony, California, and carried, the second section of the report, endorsing the resolutions declaring that all public opinions on general social, legislative and economic relationships of medical practice be made only through approved channels of the American Medical Association, was adopted.

Cable Message from the British Medical Association

The Secretary read a cablegram received from the Secretary of the British Medical Association:

"Council of the British Medical Association regrets inability to appoint delegate, but sends fraternal greetings and best wishes for successful annual session.

Anderson, Secretary,

British Medical Association."

Greetings from the Canadian Medical Association

Dr. T. C. Routley, who was one of our Guest Speakers at the December (1932) Tri-State Medical Conference, said:

I bring you most cordial greetings from your colleagues in medicine in Canada. The president has desired me to say to you that you will all be welcome in Canada any time you care to come and honor us with a visit.

I am looking forward with great pleasure to renewing old friendships here and making some new ones. I do thank you most cordially for the kindly way in which you have received me.

Sympathy for Dr. Welch

Dr. Grant C. Madill, New York, moved that the Secretary be requested to extend by telegram a message of sympathy and best wishes for the recovery of Dr. William H. Welch, Baltimore, who is ill. The motion was seconded by several members of the House and carried.

Election of Officers

Election of officers resulted as follows:

President, Dean Lewis, of Baltimore; President-Elect, Walter L. Bierring, of Des Moines, Iowa; Vice-President, John H. Musser, of New Orleans; Secretary, Olin West, Chicago; Treasurer, Herman I. Kretschmer, Chicago; Speaker of the House of Delegates, F. C. Warnshuis, of Grand Rapids, Mich.; Vice-Speaker, Nathan B. Van Etten, New York City.

Public Relations

NEW VETERANS' RELIEF POLICY

Frank T. Hines,

Administrator of Veterans' Affairs

(From N. Y. Times, Sunday, July 30, 1933.)

A new national policy governing veterans' relief is to be found in the Economy Act approved on March 20, in veterans' regulations approved by the President thereunder, and in the Independent Offices Appropriation Act for the current fiscal year, ending June 30 next. Under this new policy the estimated total cost of veterans' relief for the current fiscal year is $581,988,000, including $50,000,000 for the adjusted service certificate fund. This is $314,000,000 less than would have been necessary under the previous policy, not considering the reduction of $50,000,000 in the appropriation for adjusted compensation.

The urgent need for new legislation, including reduction of the cost of veterans' relief, was recognized by all who had studied the problem, and immediately after inauguration the President, in drawing a clear distinction between the temporary charges on the national government which were absolutely necessary in order to meet the needs of the country during the emergency and the fixed charges on the government, such as those for veterans' relief, evolved a program of economy which was later enacted into law.

Costs on the Former Basis

The cost of veterans' relief is a fixed charge on the government. It was shown for the fiscal year 1932 that the total appropriation for veterans' relief was $987,539,930.27, which included $200,000,000 appropriated for the adjusted service certificate fund. The appropriation for these same purposes for the fiscal year ending June 30, 1933, was $931,025,164.64, which included $100,000,000 for the adjusted service certificate fund.

The estimated appropriation for veterans' relief for the fiscal year ending June 30, 1934, based upon the laws in effect prior to the Economy Act, was $945,988,634, which included $100,000,000 for the adjusted service certificate fund. It was estimated upon a conservative basis that without any further liberalization in the laws the cost would mount to $1,081,200,000 for the estimated peak year, 1958. It was also estimated, upon experience in connection with prior wars, including the experience obtained in the handling of the World War group, that the appropriations for the veterans' administration alone would mount to $1,913,400,000 in an estimated peak year, 1950.

While it was appreciated that any estimates beyond a 10-year period were highly speculative, it was not believed that these estimates would transcend to any considerable amount the probable cost to the government if the laws had remained as enacted, and if they had been liberalized to include widows of World War veterans who died from non-service connected disability, and to include other provisions, following the action taken in connection with prior wars.

Principles Now Followed

The new policy fixing the national obligation for veterans' relief, taking into consideration the extent of obligation for the various groups and the

ability of the American taxpayers to meet the financial obligation involved, established the following principles:

(1) To pay the most liberal rates of pension and to furnish medical, hospital and domiciliary care to veterans disabled, and to grant pensions to the dependents of veterans who died, *as a result of injury or disease incurred or aggravated in the military or naval service in time of war;*

(2) To grant pensions and to furnish medical, hospital and domiciliary care to veterans disabled, and to grant pensions to the dependents of deceased veterans who died, *as a result of injury or disease incurred or aggravated in the military or naval service in peace time;*

(3) To grant pensions to war veterans permanently and totally disabled and in need, and to furnish medical, hospital and domiciliary care to permanently disabled war veterans, including those suffering from tuberculosis and neuropsychiatric ailments, incapacitated from earning a living and having no adequate means of support, and, except as to rates, to continue a pre-existing provision for pensions to widows and children of deceased Spanish-American War veterans who have died, *as a result of injury or disease not connected with the military or naval service.*

Modifications Made

The program was contained in the Economy Act. In perfecting veterans' regulations authorized under this act the President recognized the fact that certain groups and classes may have been adversely affected where it was not so intended, and in view of that fact authorized a continued study of the effects of the regulations for the purpose of having the Veterans' Administration recommend proposed changes therein. Under date of June 6, 1933, the President approved 4 amendatory regulations, liberalizing the provisions of 4 of the 12 regulations promulgated on March 31, 1933.

In addition, the Congress, after reviewing the effects of the law and regulations, incorporated in the Appropriation Act for Independent Offices certain amendments to the Economy Act. The purpose of these was (1) to protect the interests of those veterans who previously were accorded service connection under a provision of law presuming service connection where the disease was shown to exist within approximately 6 years from date of discharge; (2) to authorize a minimum pension of $15 per month to any veteran of the Spanish-American War who served 90 days or more, was honorably discharged, is 55 years or more of age, 50% disabled, and in need; (3) to provide for no reduction in the case of dependents of deceased World War veterans whose death had formerly been service-connected by presumptions not accorded under the new law regulations; and (4) to limit the reduction in directly service-connected cases to a maximum of 25%.

The New Laws Explained

As the law and regulations now stand, the following summary will indicate the effects on particular groups:

(1) Service-connected war-time cases suffer little or no reduction and there is a provision that the reduction cannot be more than 25%. The average reduction in these cases is about 10%. In establishing the rates for war-time service, rates comparable to the more liberal rates allowed World War veterans under prior laws have been adopted; and as the new law treats the Spanish-American War veterans and World War veterans alike, those Spanish-American War veterans who incurred disability during their war service may receive higher rates than they have heretofore been entitled to.

Moreover, there is a provision for the presumption of service connection in the case of Spanish-American War veterans formerly receiving service pensions (non-service-connected disability) who would be confronted with difficulty in attempting to establish service connection of those disabilities. This presumption is rebuttable by medical judgment or affirmative evidence. In addition, those veterans who served 90 days or more, war-time, are afforded a presumption of service connection for chronic disease arising to a 10% degree within 1 year and in the case of active tuberculosis within 2 years from date of discharge.

For service-connected war-time disabilities, veterans under the new policy will receive as high as $250 per month. Whereas there were many inequalities in the intermediate rates between the minimum and maximum under prior laws, under the new policy the rates will be uniform and for some groups more liberal than under the prior laws, particularly in connection with the more serious disabilities.

Peace-Time Cases

(2) As to service-connected peace-time cases, the elimination of rank as a factor and the fixing of rates for this group at one-half of the rates accorded the war-time cases will produce increases in some cases and decreases in others, but the result is a uniform system of administering benefits. Peace-time veterans, service-connected, receive as high as $125 per month. Whereas there were many inequalities in the intermediate rates between the minimum and maximum under prior laws, under the new policy the rates will be uniform and for some groups more liberal than under the prior laws, particularly in connection with the more serious disabilities.

(3) The non-service-connected disability class represented the greatest problem, inasmuch as under prior laws, even though the disability was not service-connected, pensions of from $12 to $72 per month were paid to Spanish-American War veterans, the rates being for degrees of disability and/or age. In adopting the most liberal rates, within the ability of the government to pay, for the war-time service-connected disabilities, and those second in liberality for the peace-time cases, it was necessary to effect greater reduction in the cases without service connection. For non-service-connected disability the World War veterans had received from $12 to $40 per month, depending on degree of disability. Under the new law and regulations the only rate is $30 per month (which is for permanent total disability).

However, provision is made for Spanish-American War veterans 55 years of age or over, 50% disabled and in need, a pension of $15 per month being allowed these persons. In addition, those Spanish-American War veterans who are over 62 years of age are granted a pension of $15 per month. The widows of Spanish-American War veterans who died of disabilities not connected with service are reduced to $15 per month instead of the $30 they formerly received. It should be borne in mind that if the disability or death is service-connected, either war-time or peace-time, the rate is higher.

Hospital Care Restricted

Hospital treatment and domiciliary care are assured to all service-connected cases, and as to the non-service-connected cases ample provision is made in needy cases. It was necessary to restrict hospitalization and domiciliary care within the limits of the Veterans' Administration facilities, thus discouraging the perpetuation of additional cost by way of constructing and maintaining more hospitals. The new policy does not obligate the government to provide hospital treatment for acute temporary conditions not connected with the military or naval service, solely on the basis that the man served in the military or naval service. The regulations do provide, however, for the care of permanent conditions, including tuberculosis and neuropsychiatric ailments.

Under the previous policy World War veterans enjoyed a presumption of service connection for certain diseases shown to have arisen to a manifest degree within about 6 years after date of discharge. Presidential regulations provide for a presumption of service connection for a chronic disease arising within 1 year from date of discharge and in the case of active tuberculosis 2 years. Beyond this the President did not feel justified in going.

Boards of Review

It was considered that in some instances a determination of service connection might be supported where previously granted, if such cases were reviewed without strict adherence to the new regulations and from the standpoint of giving the veteran the benefit of any reasonable doubt in trying to preserve his right to service connection. Rather than to remove from the rolls all of those cases which would not conform with the Presidential regulations, the Congress provided for the creation of *special review boards to pass upon all cases where the service connection was granted by statutory presumption.*

These boards are now being organized, and the benefits to the presumptive cases will be continued at a 25% reduction in their former rate, effective July 1, 1933, and to continue until October 31, or until the final decision of the Special Review Board in each case, whichever is earlier. The Special Review Boards may grant service connection if, from all the evidence, in their judgment service connection is supported, even though the case does not technically meet the requirements of the new regulations.

Retirement Pay

Another important change effected by the new law is the provision with reference to emergency officers' retirement pay, which will *remove from the rolls those cases wherein service connection was based upon statutory presumption.* It is required that there be shown in such cases a causative factor arising out of war service which resulted in incurrence or aggravation of the disease or injury causing the disability for which retirement with pay was granted. The new law did not extend the period for filing claims, but applies only to those receiving retirement pay at the date of the passage of the act, March 20, 1933. It, therefore, means that all of those cases which had been granted up to that time and where the retired officer was receiving benefits, are being reviewed for the purpose of determining whether each case meets the requirements of the new law.

In viewing the effects of the new policy it was contemplated that many who were forced to make a larger contribution to the economy program would feel that an injustice was being done; and in some instances it was contemplated that certain groups might feel that they had not been amply provided for or, not having been included, should be included among those receiving certain benefits. For this reason, under instructions from the President, the Veterans' Administration is conducting a continuous study of the effects of the regulations and is carefully considering all proposals for changes in them. Proposed changes found to be clearly supported by study will be submitted to the President for consideration.

Inequality of Old Laws

The foregoing policy was made necessary not only on account of the financial condition of the government and the excessive cost of veterans' relief, together with the anticipated increase in such expenditures if the prior laws were continued, but also because of the numerous inequalities in the prior laws. The rates for the same disabilities incurred in war-time were different as to the veterans of the several wars. The prerequisites for entitlement were not similar. There was a glaring lack of uniformity in the provisions for those men who should receive similar consideration. The laws governing the rates for the regular establishment, i. e., peace-time service and war-time service, were very difficult to administer, for there was no uniform system and certain criteria and factors were applied in some instances and not in others. This is also true with respect to special statutory allowances granted in some instances and not in others.

The chief cause of inequalities just mentioned is believed to be the fact that all earlier legislation has to be taken up, piecemeal as it were, and the needs of each group of veterans had to be handled separately because the benefits were dispensed or administered by several different governmental agencies and legislation pertaining to their affairs was handled by different committees in both houses of Congress. For these reasons it was impracticable for Congress to arrange all groups of veterans and benefits in classes for comparative study and then to correct or eliminate certain features by one piece of legislation.

Prior Laws Set Aside

A repeal of the prior laws was found necessary in order to accomplish the required financial adjustment in the fixed charges for veterans' relief in the most equitable manner. Owing to the numerous inequalities under prior laws and the lack of a clear-cut indication of the national obligation to veterans, it was necessary to define the extent of obligation to each group of veterans and to establish rates as liberal as possible, bearing in mind the ability of the government to meet the expense involved.

Furthermore, by the establishment of the new laws, a more simplified administration is effected and uniform treatment of the veterans of the Spanish-American War, Philippine insurrection, Boxer rebellion and the World War is assured.

Pending operation and careful study under the new laws and regulations over a reasonable length of time, it is impracticable for veterans or dependents of deceased veterans to know exactly what the effects will be, and in view of the fact that the laws and regulations extend over the whole field of relief, and that the vast majority of classes and groups have been carefully considered, it can be assumed that those cases wherein there is a just

claim upon the national government for relief are adequately taken care of. This is the general rule and it is understood that there may be some exceptions. For that reason, perfection of the application of the new policy and the rounding out of the program will be accomplished gradually by considering proposed changes and making submissions to the President where indicated, to relieve injustices.

It is believed that future years will demonstrate that President Roosevelt, by establishing a new national policy in dealing with our veterans upon sound principles, has performed a service not only in the interests of the country but in the interests of the veterans as well.

A LLOYD GEORGE TRIUMPH

(An editorial in the New York Times of July 15, 1933)

When Dr. McCleary, once Principal Medical Officer of the National Health Insurance Commission for England, was here a few weeks ago he discussed certain phases of the Health Insurance Act. The Twenty-First Anniversary of its adoption is being celebrated in England this week. Mr. Lloyd George, who vigorously advocated it, spoke of it as conferring upon millions of citizens the greatest alleviation of the risks and sufferings of life "that any Parliament has ever conferred upon any people". It was bitterly opposed at the time, but now more than 15,000,000 workers avail themselves against the time of sickness or injury. The question of which Dr. McCleary spoke, in response to American inquiries, was—"what effect has the scheme had on the quality of medical service given".

His answer was that the plan rested on 2 basic principles: (1) That it should provide each insured person with the services of a family physician. (2) That insurance medical practice should resemble private practice as closely as possible. Every insured person has free choice of the physicians who have elected to take part in the service; and every physician has the right to undertake medical treatment of the insured. There are 15,000 Insurance Physicians in England and Wales, which gives each an average constituency of 1000 persons who may come to him for consultation. A maximum limit is fixed, however.

The doctors as a whole, in any community, accept a "collective responsibility" for all insured persons. They pledge themselves that they will leave no insured person without medical care. Their fees are assured, an average of £450 ($1250 at normal exchange rate), and they are not forbidden to have general practice. As a matter of fact, the Insurance Physician is the ordinary practitioner of the country.

Lloyd George has good reason to rejoice over the working of this measure, of which he said: "none was more needed and less wanted 21 years ago".

State Health Department

MINIMUM STANDARDS OF SANITATION

J. Lynn Mahaffey, M.D.,
Director, State Department of Health,
Trenton, N. J.

Minimum standards of sanitation for roadside stands and other places where food and drink is sold to the public for immediate consumption have been promulgated by the State Department of Health. Two sets of standards are provided. Class A includes places where food and drink is not removed from the original container for serving. All other places are grouped in Class B.

The Department considers the proper cleansing of eating and drinking utensils one of the most important regulations. Communicating with local boards of health, the department said: Eating places and refreshment stands along the highways throughout the State present many problems of sanitation. All food vending establishments should be inspected more frequently than is now done in a number of small communities.

As a representative of the local Board of Health, you will agree that inspection by health officials and insistence upon reasonable standards of sanitation at such establishments, should be carried out. As a guide for both health officials and proprietors of eating places, the Department has prepared a set of *standards of sanitation* which, it believes, should be followed at all such establishments as the *minimum to maintain cleanliness and to protect health.* A copy of these minimum standards has been sent to all local Boards of Health.

This Department deems it urgent to have at least these minimum standards enforced at all food and drink vending establishments and the first step toward this goal is careful inspection of existing conditions.

Many local Boards of Health are already making such inspections. To aid in furthering the work, this Department is willing to assist local Boards as much as is practical, at least in inspecting places where food is consumed on the premises, in sections to which a District Health Officer is assigned.

County Society Reports

ESSEX COUNTY

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

The Academy of Medicine of Northern New Jersey has planned a very active year beginning its twenty-third season in October.

The speakers for the October meetings are: Dr. Russel L. Cecil, Professor of Clinical Medicine, Cornell University Medical School, whose subject will be "Rheumatic Fever". Dr. Alfred Cowan, Assistant Professor of Ophthalmology, University of Pennsylvania, Graduate of School of Medicine, will speak on "Standard Forms of Ophtha'mic Lenses". Dr. Willis S. Knighton will also be a guest on October 9, 1933. Dr. Frank Leahy, of Boston, will speak at the Stated Meeting, October 19, 1933.

The entire program for the Winter season is practically complete and some of the guests for the meetings will be: Dr. Schick, of New York; Professor Atchley, Columbia University; Professor Wyckoff, of New York University; Dr. Frazier, of Phi'adelphia, will be an essayist.

Obituaries

PERKINS, James Locke, 56 years old, one of New Jersey's most widely known surgeons, died August 15, at 4 o'clock in St. Elizabeth Hospital, Elizabeth, following an operation for a stomach ailment. He had been ill about 4 weeks.

A Fellow of the American College of Surgeons, he was considered one of the foremost men of his profession in the State. He was associated as a surgeon with St. Elizabeth Hospital and Rahway Memorial Hospital, and had operated before various surgeons' clinics. He was a member of the American Medical Association, the New Jersey State Medical Society and the Union County Medical Society.

It was said at the hospitals with which he was affiliated that he was an excellent instructor, and that he took great interest in the younger doctors on the staffs, being always willing to divulge his wealth of surgical and medical knowledge. He is said also to have done a tremendous amount of work for charity.

Dr. Perkins was born in Concord, N. H., in November 1876, a son of the late Charles C. and Martha F. Perkins. His college and medical courses were taken at Yale where he received his doctor's degree in 1898. He came to Cranford in 1899. He made his home at 16 Alden street.

A man of prodigious strength, he had weighed, before he was taken ill, nearly 200 pounds. He is said to have been particularly courageous and frequently undertook surgical cases which had been considered hopeless. He was fond of sports, being a fine trapshooter, an excellent marksman, and a fisherman of considerable ability. He was a lover of animals and had owned saddle horses and pedigreed dogs. His library of books on medicine and surgery is said to be one of the best private collections in the country.

Dr. Perkins was first taken ill about a year and a half ago. At that time he underwent an operation at the Deaconess Hospital, Boston. Regaining his strength, he resumed practice immediately. It is believed by some of his friends that overwork contributed no small part to his final illness.

He was a member of Azure Lodge, No. 129, F. & A. M., of Cranford; Salaam Temple, of the Shrine, Newark; Elizabeth Lodge of Elks; Cranford Rotary Club, Belmar Yacht Club, Nomahegan Golf Club, Trinity Episcopal Church and Trinity Men's Club.

Surviving him are his wife, Mrs. Harriet Munoz Perkins; a daughter, Miss Christine Elizabeth Perkins, both of Cranford, and a brother, Ernest W. Perkins, of Boston.

Resolutions On The Death of Dr. Perkins

The Union County Medical Society in special meeting assembled records the death of Dr. James Locke Perkins.

Dr. Perkins was a practicing physician in this County for over 30 years. During that time he achieved a deserved prominence in the profession. While doing general practice he perfected himself and became one of the leading surgeons in the County. He was an Attending Surgeon at the St. Elizabeth Hospital, Elizabeth, and a Fellow of the American College of Surgeons. He had a large practice, was devoted to his patients, and in return practically all of his patients were his staunch friends and admirers.

The Union County Medical Society feels that in his death, the community has lost a devoted friend and servant, and the Society an eminent and valuable member.

It records its sorrow and extends to the bereaved family its heartfelt sympathy.

It is also resolved that these resolutions be spread upon the minutes of the Society, and that copies be sent to the bereaved family, and to the press.

(Signed) Irving Lerman
Thomas J. Walsh
W. E. Boozan

SINCLAIR, Donald Bunker, 45 years of age, died August 9, at his home, 140 Hodde Road, Princeton, N. J.

Dr. Sinclair was born in New York City. He was a graduate of Princeton University, 1910, and of the College of Physicians and Surgeons at Columbia, 1914.

He served as a surgeon during the World War in the A. E. F. and after the war became a member of the medical staff at Princeton University. He was a member of the New Jersey Medical Society.

He is survived by his widow, Harriet, 4 daughters, Alice, Frances, Doris and Elizabeth, and 1 son, John.

WINTER, Daniel T., who made his home at 8 Gifford avenue, Jersey City, died August 26, while on his way from Englewood Country Club, where he had played a round of golf during the late afternoon. He was 48 years old.

Apparently in good health, Dr. Winter had gone to the Englewood club Saturday and started his round with customary enthusiasm. Friends who were playing with him said that as the match wore on, however, he appeared to tire and that his play was below his usual standard. Dr. Winter usually played in the "eighties".

After the match had concluded, Dr. Winter appeared to be in normal health and he complained of no illness. At 10:30 p. m., while returning home through Union City, however, he stopped at the Palisade avenue restaurant and asked that a call for assistance be sent to the Medical Center. He then collapsed and had expired when Dr. Birnberg, who answered the call, arrived with an ambulance.

Death was due, apparently, to a heart condition, which had given but slight warning during the golf match—a warning which the doctor himself had failed to heed in his enthusiasm for the game.

Dr. Winter was Chief Visiting Surgeon of Jersey City Medical Center, and was widely known for his skill as a surgeon, some of the operations he performed having attracted wide attention throughout the profession. His institutional work was confined to the Medical Center, during recent years, although previous to his appointment to the post he held there he had owned and operated the Bergen Sanitarium in Jersey City.

Although a native of Pine Hill, N. Y., Dr. Winter had resided in Jersey City for over 25 years. He had prepared for and received his degree in medicine at the University of Vermont, in Burlington.

Dr. Winter was a member of the Hudson County Medical Society and of the New Jersey State Medical Society. He was also a member of Enterprise Lodge, No. 48, F. & A. M., and of Salaam Temple, A. A. O. N. M. S. He had held membership in the Englewood Country Club for a number of years.

Surviving Dr. Winter are his wife, Mrs. Enna Davidson Winter; 2 sons, Daniel T. Winter, 3d, and John Davidson Winter, and a sister, Mrs. Joseph Mason, of Jersey City.

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SUPPLY

87 HALSEY STREET MArket 3-4280—4281 NEWARK, N. J.

SEVERAL POINTED QUESTIONS

Dr. W. H. Ross, Brentwood, N. Y.: How far can the State go in activities hitherto largely dependent on private initiative for leadership? One can easily visualize increasing difficulty for the taxpayer if the State increases its public medical care. The State has no money except that which comes from the taxpayer. We as a nation cannot spend money indefinitely. Any increase in public medicine means an increase in paternalism. Is this for the best interests of society? The cost of work relief in New York State has increased from $2,500-000 to more than $100,000,000 in 2 years. We have accepted for a long time the obligation of providing food and shelter and clothing for every individual and now we have added to these medical care. If the number of individuals requiring these things grows, a redistribution of wealth will be necessary and a reorganization of that which was thought to be standard. I am not objecting to public medicine if we as taxpayers can pay the bill. Can all these things continue without bringing about taxpayers' bankruptcy? The State has become tremendously powerful. It has come to have vast resources. There is an alarming tendency to have the State do things and the result may be a disturbance of our social formation. We have today in government controls of all kinds—commerce, currency, industry. I doubt whether it can go much further without imposing an impossible burden on the taxpayer. If State intervention goes too far into the realm of private initiative, is there danger that it will absorb social effort which has hitherto been thought to be the most effective means for advancing public welfare? One wonders whether emotionalism is playing a part in public medicine. We need the assistance of the State in medicine but do we need the State as a dictator in medicine? The indications are plain of the trends in public medical care at the taxpayers' expense, but is it the best thing for society to have its personal initiative diminished by giving more than it can get for itself?

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RETAIL PHARMACISTS ADOPT TRADE CODE

(New York Times)

The Eastern States Pharmaceutical Conference, consisting of Delegates from the New Jersey, New York, Massachusetts and Connecticut State Pharmaceutical Associations, representing 30% of the retail pharmaceutical outlets of the United States, drafted a tentative code of fair competition, under the provisions of the National Industry Recovery Act. The code fixes minimum wages, maximum working hours, minimum resale prices and eliminates unfair trade practices.

The minimum wage regulations would guarantee all registered pharmacists employed as clerks a minimum weekly salary of $30, licensed assistants $20 and other sales people $15 a week for men and $12 a week for women. All sales people in this category will be required to be 18 years old or more. Maximum hours of labor are fixed at 54 hours a week.

The code also called for a minimum resale price on nationally advertised proprietary remedies based upon the wholesale list price of the items, plus overhead charges, plus 5% profit.

The code will be submitted to the Drug Institute of America and if it rejects or fails to act upon it within 10 days, the pharmaceutical program will be offered direct to the National Recovery Administration on behalf of retail pharmacists in this section of the country.

Representatives of the New Jersey State Pharmaceutical Association who attended the conference were Walter Woolley, President, Asbury Park; Prescott R. Lovcland, Secretary, Atlantic City; Robert Fischelis, Secretary of New Jersey State Board of Pharmacy, Trenton; Raymond Williams, Asbury Park; and A. S. Sherwin, Newark.

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TOO MANY DOCTORS?

(The Common Weal)

Among the most significant of the reports presented before the Annual Meeting of the American Medical Association in Milwaukee, as noted in the press, is one having to do with America's present over-production of physicians. Without having the actual figures before one, it is impossible to say on what per capita allowance the alleged surplus of 25,000 physicians is based; but if "the ratio of physicians to the general population is twice as great here as in England, France and Germany" (to quote the newspaper paraphrase of the report on this point), the existence of a surplus, it seems, cannot very well be denied. These countries stand so high in medical science that only the belief that Americans are twice as unhealthy as Englishmen, Frenchmen or Germans could equalize the discrepancy. For 10 years, it appears, the number of graduates from our medical colleges has been mounting, until their number greatly exceeds the death rate of practicing physicians. In support of these statements, one fact will leap vividly to the mind of even the layman least instructed in this matter: the grave and increasing concern which the responsible body of physicians has been making public over the inability of a large number of their profession to earn an adequate living. The various projects for socialized or group medicine (incidentally, these terms should not be used synonymously) stem from this fact; and though the fact has other causes, a superfluity of doctors may quite logically be one of them. A severe limitation of enrolment in our medical colleges, as is urged by the report, will help to solve the problem numerically. It should also make a qualitative difference which superior members of the medical fraternity will be the first to welcome.

RESOLUTION ABOUT TECHNICIANS AND NURSES AS ANESTHETISTS

(Journal A. M. A.)

At the recent Annual Meeting of the Medical Society of the State of New York, a resolution was adopted urging that the giving of anesthetics by nurses and lay technicians be discontinued. Declaring that for many years the Medical Practice Act of the State had been interpreted to mean that administering of anesthetics by any persons except licensed physicians and dentists was illegal, the resolution pointed out that during the past 10 years lay technicians have usurped the duties and rights of licensed physicians in this field. The spirit of the law is evaded, it was said, by the technical assumption of responsibility by the surgeon, but in fact the surgeon rarely selects or inquires into the anesthetist's qualifications and does not usually see the patient during the induction of anesthesia. This growing custom is depriving interns and residents of opportunity for instruction in this branch of medicine, yet they are the practitioners of the future who will be called on to assume responsibility for administration of anesthesia. The resolution urged the society to insist on a strict interpretation of the Medical Practice Act and, if the Attorney General was of the opinion that the present act does not adequately cover the situation, to institute measures to obtain proper legislation to limit administration of anesthesia to licensed physicians and dentists.

PRESIDENTS, SECRETARIES AND REPORTERS OF COUNTY SOCIETIES

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HUDSON	Louis A. Pyle, Jersey City	B. T. D. Schwarz, Jersey City	Charles Sirken, Jersey City
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MERCER	Francis E. Proctor, Trenton	A. Dunbar Hutchinson, Trenton	A. Dunbar Hutchinson, Trenton
MIDDLESEX	William C. Wilentz, P. Amboy	Edward F. Klein, Perth Amboy	Edward F. Klein, Perth Amboy
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The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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NOTHING SURPRISING

(Newark Evening News)

So much has been said in recent years of the increase in mental cases in State institutions that no astonishment is created by the statement of Colonel Bullis, Executive Officers of the National Committee on Mental Hygiene, "one person out of every 22 becomes a patient in a mental hospital for some time during his or her lifetime". It tallies with the American Medical Association's report that more than half the patients in all hospitals, public and private, are mental patients.

To many people such statements cause alarm yet it is not surprising, when we think of it, that the most delicate and highly organized organ of the human body should account for at least half the ills of the people as they are registered in the hospitals. Nor is it strange that as life becomes more complicated, putting more severe strain on the mental and nervous systems, the number of mental cases should increase, although this increase may not be as great as the figures indicate. The old state of mind which looked upon a nervous breakdown as a stigma upon the unfortunate person or his family is outmoded. We now recognize such breakdowns as occurrences on a par with other human afflictions and no more of a taint on the family escutcheon than any other disease. The old-fashioned effort to conceal them is disappearing.

Some of these mental troubles might be avoided if life could be lived at a slower pace, but not a great deal is to be expected along that line. More is to be hoped for from spurring the use of recreational facilities and cultivating a better use of leisure. Each generation has to learn to live under the conditions which surround it. As conditions change, adjustments in our ways of living have to be made. The goal of a sound mind in a sound body is the same for every generation although there must be different ways of attaining it. Responsibility for reaching is both personal and social. Happily this generation is realizing the wisdom and economy of prevention.

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Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ... Aldrich C. Crowe, Ocean City (1935)

DELEGATES

Delegates to the American Medical Association

Walt P. Conaway	Term expires		1934
John F. Hagerty	"	"	1934
E. R. Mulford	"	"	1935
A. Haines Lippincott	"	"	1935

Alternate Delegates

Philip Marvel	Term expires		1934
George H. Sexsmith	"	"	1934
S. B. English	"	"	1935
Stephen T. Quinn	"	"	1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section	*Chairman*
Eye, Ear, Nose, Throat	S. T. Hubbard, Hackensack
Pediatrics	Walter B. Stewart, 8 N. Tallahassee Ave., At. C'y
Radiology	C. B. Kaighn, 905 Pacific Ave., Atlantic City
School Physicians	A. G. Ireland, Trenton Trust Bldg., Tr'n

STANDING COMMITTEES

Committee on Scientific Work

Louis C. Lange, *Chm.*, Weehawken	Term expires		1934
Ralph K. Hollinshed, Westville	"	"	1935
Clarence C. Andrews, Atlantic City	"	"	1934

Committee on Publication

Henry C. Barkhorn, *Chm.*, Newark	Term expires		1936
Edward J. Ill, Newark	"	"	1934
Linn Emerson, Orange	"	"	1935
Frederic J. Quigley			Ex-officio
J. Bennett Morrison			Ex-officio

Committee on Finance and Budget

Harry R. North, *Chm.*, Trenton	Term expires		1939
Alfred Stahl	"	"	1934
James S. Green	"	"	1935
Herschel Pettit	"	"	1936
William G. Herrman	"	"	1937
William J. Sweeney	"	"	1938

Committee on Program and Arrangements

William J. Carrington, *Chm.*, Atl. City	Term expires		1935
John W. Gray, Newark	"	"	1934
William D. Olmstead, Atlantic City	"	"	1936
Frederic J. Quigley, Union City			Ex-officio
J. Bennett Morrison, Newark			Ex-officio

Committee on Honorary Membership

Thomas W. Harvey, *Chm.*	Term expires		1934
W. E. Darnall	"	"	1935
Ephraim R. Mulford	"	"	1936

Committee on Hospitals and Medical Education

Harry H. Satchwell, *Chm.*	Term expires		1936
William W. Brooke	"	"	1935
Arcangelo Liva	"	"	1934

John H. Carlisle
Charles H. deT. Shivers
William R. Little
Louis A. Pyle
Dan S. Renner
J. Vincent Smith
Stuart Z. Hawkes
Charles B. Kelley
Earl H. Snavely
Elmer P. Weigel
Hugh H. Tyndall

Committee on Medical Defense

C. C. Beling, *Chm.*
John C. McCoy
E. Reissman
Edgar A. Ill
William J. Arlitz

Committee on Insurance

Frank W. Pinneo, *Chm.*
Barclay S. Fuhrmann
Edmund N. Huff
Warren D. Robbins
W. L. Williamson
A. Dunbar Hutchinson
Wayne W. Hall

Committee on Welfare

(To be announced)

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Public Health Committee

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Ernest G. Hummel ..... 414 Cooper St., Camden
Joseph C. Schapiro ..... 712 Palisade Ave., Union City
Theodore Teimer ..... 17 Hillside Ave., Newark
F. C. Johnson ..... 51 Livingston Ave., New Brunswick
Julius Levy ..... State Dept. of Health, Trenton
Allen G. Ireland ..... State Dept. of Education, Trenton

Committee on Maternal Welfare

Arthur W. Bingham, *Chm.*, 144 Harrison Ave., East Orange
R. A. MacKenzie ..... 501 Grand Ave., Asbury Park
P. Dubois Bunting ..... 712 N. Broad St., Elizabeth
John F. Condon ..... 686 Mt. Prospect St., Newark
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Committee on Constitution and By-Laws

(To be announced)

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COUNTY STUDIES HOSPITAL COSTS

(Newark Evening News)

Efforts by institution officials to keep county hospitals "out of the red", as increased costs loom for the remainder of the year, engaged freeholder committees. Collections from families of patients as an element of profit were studied and it was agreed at a session in the Isolation Hospital, Belleville, a county collection agency, under direction of County Auditor Cash, may solve the question of, getting increased payments.

The Belleville institution expenses, due to a heavy increase in number of patient days over last year, are now $10,932.96 more than the budget allotment for the first 7 months this year. A pick-up was experienced last month when expenditures were $595.95 under the month's budget sum. However, collections for patients' care, which were anticipated to reach $7500 for the year, were $7686.75 for the first 6 months.

Freeholder Lindeman, purchasing committee head, sounded the warning of higher commodity costs. If, as expected, these rise, the committee may change the rate of $1 per day to $2. Chairman Lehmann of the Isolation Hospital Committee, and Chairman Muir of the Finance and Verona committees were named to work out some such plan for the Belleville and Verona hospitals.

Director Crane and others agreed charges for patients were low and should be brought more in line with charges at Overbrook Hospital. Lehmann pointed to the Belleville institution as a different problem. State aid is given Overbrook and Verona institutions and the isolation hospital gets no such support and, in addition, has the problem of taking cases promptly to prevent disease spread, without court orders for costs. Auditor Cash will ascertain from County Counsel Vanderbilt the power of the county to sue in court to collect unpaid bills. Thus far in 1933 the isolation hospital has spent $185,641.27. The budget for 7 months was $174,-708.31.

Mrs. Elizabeth A. Harris, Chairman of Overbrook Hospital, told her committee that while expenditures to date were $9658.49 under the budget "this ba ance may be delusive, as there is a rocky road ahead in the next 3 or 4 months". She advised the "hazard" be anticipated. Thus far this year $551,035.94 has been spent. The annual budget is $976,800.

Despite the hospital's efficient collection force patient payments, anticipated at $175,000 for the year, have totaled only $79,232.68. Hard times was the Chairman's explanation. Many families are asking a reduction in charges. The collections are $13,000 behind last year at this time.

TO JOIN CORNELL MEDICAL FACULTY.

(New York Times)

Dr. Robert Allan Moore, instructor in pathology of the School of Medicine of Western Reserve University and assistant pathologist of Lakeside Hospital, Cleveland, has accepted a call from Cornell University College of Medicine in New York City, as assistant professor of pathology. He is a member of the American Association of Pathologists and Bacteriologists and of many other medical societies. Dr. Moore is a native of Chicago. Mrs. Moore, the former Ruth Miller of Columbus, Ohio, will accompany him to New York. They have a son 9 years old.

Dr. Edward M. Finesilver, of the Medical Tower, has been appointed for the second year an Instructor in Surgery at the Cornell Medical School and Assistant Surgeon to the New York Hospital.

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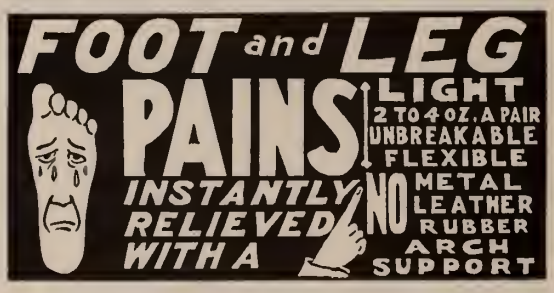
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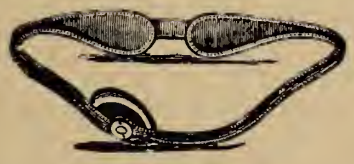
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Issued as a Supplement to the September 1933 Journal

OFFICIAL TRANSACTIONS

167th Annual Meeting of the Medical Society of New Jersey

Held at Haddon Hall, Atlantic City, June 6, 7, 8, 9, 1933

HOUSE OF DELEGATES

Tuesday Afternoon Session

June 6, 1933

The first session of the House of Delegates of the 167th Annual Meeting of the Medical Society of New Jersey convened in the Viking Room of Haddon Hall, Atlantic City, New Jersey, at 2.15 p. m., with the President, Dr. A. Haines Lippincott, of Camden, in the chair.

President Lippincott: It is my privilege to declare the 167th Annual Meeting of the House of Delegates of the Medical Society of New Jersey open for the transaction of business. I appreciate the honor of presiding over the deliberations of this body, but I hope you will be charitable to your presiding officer, for I am not a parliamentarian.

We will have the invocation of prayer, by the Rev. Robert Arthur Ellwood.

Rev. Robert Arthur Ellwood: Let us, first, stand in silence as a tribute of respect to the memory of those physicians of this State who have died during the past year:

> Comrades of service—
> On Fame's eternal camping ground
> Their silent tents are furled
> And glory guards with solemn round
> The bivouac of the dead.

Father in heaven, we are grateful for this beautiful day, thankful for the opportunity to enjoy the fellowship that comes in this Convention, and we pray Thy blessing upon all its transactions as they are performed for the benefit of humanity. We pray that Thou wilt grant during the coming days of its session, there may be given consideration of healing that shall be helpful to those who are ill.

We come to Thee, grateful for the knowledge of that Great Physician whose mighty hands did the healing for not only men, but for nations. We pray that in the spirit of the Master may these servants of Thine be able "to go about continuously doing good". Keep them during their convention; bless them in their fellowships; grant that they may form friendships that shall be enjoyable for the years to come; and grant, we pray Thee, to keep them safe and return them to their homes with a greater zeal and a greater spirit of service than they have ever before experienced. Watch over our loved ones; be with Thy children everywhere; and grant, O God, that we may realize the fact that these lives were given to us for usefulness, and when the end of the journey comes, may we be able to hear Thee say: "Well done, good and faithful servant." We ask it, in the Master's name. Amen.

President Lippincott: We will now have an Address of Welcome, by the Secretary of the Chamber of Commerce, Mr. Thomas T. Husselton, in place of His Honor, the Mayor.

Mr. Thomas T. Husselton: Mr. President, Ladies and Gentlemen: It has always seemed to me something rather foolish to extend to any group of residents of the State of New Jersey a welcome to Atlantic City. But, it is one of those things, I suppose, that has been going on for so long a time that it has become a habit. So, as the representative of the Mayor, and also the representative of the people who live in Atlantic City, I welcome you to this city of ours.

The Mayor, as you probably know, is also a Public Utilities Commissioner, and it is on Tuesdays that Commission regularly meets. Consequently, it was impossible for him to be here today, and that is the reason for my appearing in his place.

Without any further ado, Mr. President, I am going to present to you this key, copies of which you may have seen before, but which nevertheless carries with it always the very best wishes of the people of Atlantic City.

President Lippincott: Address of welcome by Dr. C. H. deT. Shivers, President of the Atlantic County Medical Society.

Dr. Shivers: Mr. President, Members of the House of Delegates and Fellow Members of the New Jersey State Medical Society: As President of the Atlantic County Medical Society, I take great pleasure in welcoming this convention to Atlantic City. Our President,

Dr. Lippincott, through his committees, has arranged an excellent program. I want, personally, to congratulate him upon his success in arranging especially the Symposium on Urology. Through his affiliations, he has been able to secure for us some of the best, nationally known, men in this specialty, and I am quite certain that this afternoon will be a profitable one, not only to the urologists, but to the entire profession.

The officers and members of the Atlantic County Medical Society stand ready to assist the State Society in any way possible during this convention. I hope, Mr. President, you will feel at liberty to call upon me at any time during your stay in Atlantic City.

President Lippincott: I have at this time 3 committees to appoint, as follows:

Business Committee. Drs. W. Blair Stewart, Atlantic City; Thomas B. Lee, Camden; Stephen T. Quinn, Elizabeth; J. F. Hagerty, Newark; and Richard M. A. Davis, Salem.

Constitution and By-Laws. Drs. Frederic J. Quigley, Union City; George H. Lathrope, Newark; and J. B. Morrison, Newark.

Resolutions and Memorials. Drs. Ephraim R. Mulford, Burlington; Lyman B. Hollingshead, Pemberton; and William F. Costello, Dover.

We will now have the reading of the Minutes of the 1932 meeting.

Secretary Morrison: Mr. President, inasmuch as they were published, as a supplement to the Journal of September, 1932, I move that the published report be accepted as the reading.

The motion was adopted.

President Lippincott: Report of the Committee on Arrangements and Program, Dr. Olmstead.

Report of the Committee on Program and Arrangements

Mr. President and Members of the House of Delegates: It is with the most profound sorrow and the deepest regret, that we must record the "passing o'er the great divide" of Dr. Reddan, who had been Chairman of this Committee for nearly 11 years. His advice and counsel have been of inestimable value to the Society, and because of the zeal with which he served us, we feel sure the Society will take adequate measures to record his services.

In like measure would we record the passing of Dr. William G. Schauffler who served with Dr. Reddan and the speaker from 1922 until 1 year ago. The Society and this Committee have lost 2 valued and zealous servants who were ever fearless to stand for what was right.

We have endeavored to plan a meeting compatible with the dignity and standing of our Society. Few such organizations can boast of holding so many as 167 annual meetings. The *Program* really speaks for itself and gives a synopsis of all our activities.

The Sections, you will note, meet each *morning* and the General Sessions meet each *afternoon;* thus, by staggering the meetings, we hope to avoid some of the previous complaints about so many meetings going on at the same time.

The Wednesday evening meeting on "Medical Economics" is worthy of everyone's attendance, as the subject is a vital one to all of us at present. For the ladies, on this particular evening, we have arranged a Card Party at the Hotel Claridge, in charge of the Woman's Auxiliary to the Atlantic County Medical Society.

The "Dinner Dance" on Thursday evening is well planned, with an inviting menu, good music, and, as the Program states—"no speeches, tiresome or otherwise". American plan guests pay $1 only, which is the difference between the charge for the American plan dinner and the special, more elaborate, menu which will be served to us in the Rutland Room. Members and guests not stopping at the hotel will pay $3 for a ticket, which is a moderate charge for all they will get.

As the dinner dance is planned to honor the new President, everyone should attend. Get tickets early, from our Committee, the registration desk, or from a member of the Atlantic County Woman's Auxiliary.

No financial statement can be given until after the meeting is over, when such a statement will be submitted to the Trustees, and to the Treasurer, and published in the Journal, but suffice it to say now, that due to economic conditions, we have only 4 program advertisers and more than a 50% loss in commercial exhibitors, which will make it necessary for the Society to cover a small deficit. We are still putting on as pretentious a meeting as ever. To encourage these loyal commercial exhibitors, everyone should visit and register at each exhibit. There is no obligation.

Our scientific exhibit under Dr. Downs was gotten together in 6 weeks' time and it is well worthy of a Society with the high standard of ours.

Through the activities of our esteemed President, Dr. Lippincott; the Executive Secretary, Dr. Reik; Dr. Campbell, of Long Branch; and others, we present this year, for the first time, an "Art and Hobby Exhibit".

Everyone should visit it and see in what our fellow members take an interest as a means of diversion. We predict this exhibit will grow from year to year. It is located in the Derbyshire Room, on the first floor, and is easily accessible to all.

The Woman's Auxiliary has been provided for with charming quarters and we repeat, a very delightful Card Party has been provided for them at the Hotel Claridge, on Wednesday evening, June 7, while our meeting on Medical Economics is being held. The Woman's Auxiliary of Atlantic County will be in charge.

We trust the arrangements will meet with the approval of all and that the 167th Annual Meeting will run along as smoothly as its predecessors.

Our Committee deems it a privilege to serve a Society so venerable, but possessing withal the virility of youth.

Respectfully submitted by,

W. D. Olmstead, M.D.

President Lippincott: You have heard the report of this Committee. What is your pleasure?

Secretary Morrison: I move it be accepted.

The motion was seconded, put to a vote and carried.

President Lippincott: Report of the Committee on Scientific Work.

Report of the Committee on Scientific Work

Mr. President, Dr. Olmstead has already referred to a great deal of the work that has been prepared, not only by his Committee, but by your Committee on Scientific Work.

In past years, there has been so much confusion because meetings of the Sections and the General Sessions were all running at once, that we decided this year to stagger the program, as has been suggested, and have all of our Sections meet in the mornings, and the General Scientific Sessions in the afternoons, thus having a clear right-of-way for everyone who wishes to cover the general subjects and take advantage of any of the specialties in which he is interested.

We may say, as a Committee, that members throughout the State have responded wonderfully well in offering papers and it has been almost unnecessary for us to make any solicitation of scientific material. I may say, too, to those whose contributions could not be accepted for the program, we offer our apologies in that we had to limit the number of papers for each session, and in that way could not accommodate everyone who wished to present a paper.

It has been said that the program on Wednesday afternoon, concerning genito-urinary subjects, arranged by our President, Dr. Lippincott, is unusually fine and we owe a great deal of credit to Dr. Lippincott for the excellent work that he has done in getting that program together. It has, I can also assure you, lightened very much the work of our Committee.

For Wednesday evening Drs. Morrison and Reik, by request, arranged the program, and they have obtained for us capable speakers upon the subject of *medical economics,* to give us not the varnished side of the picture, not the biased side of the question, but an honest presentation of conditions requiring consideration.

On Thursday, the medical program has been prepared largely with the object of having the practicing general physicians feel that they have a real part in the program. We are very happy to announce that Dr. David Riesman, from Philadelphia, will be our Guest Speaker, dealing with the question of "Coronary Disease", to be followed by our good friend, Dr. A. Hyman, of New York, who will take up the question of "Electrocardiography", discussing particularly some of the questions that are at present under debate.

On Friday—and I hope that, if possible, all of the Delegates will plan to stay over, and not go home because Friday is the last day and the larger part of our business is out of the way—we will have one of the very best sessions, which has been arranged by Dr. Bingham and Dr. Walt Conaway upon the question of "Maternal Welfare"; and, also, reports from the Maternal Welfare Committees from each of the County Societies.

Speaking for our Sections, may I say, the Chairman and Secretaries of those 4 Sections have done remarkably good work, and if you will look over the programs as prepared by Drs. Johnson, Ireland, Schlichter and Kaighn, for their respective Sections, you will find programs that are not only strictly up-to-date, but really, in some measure, ahead of the teachings of the day.

Respectfully submitted by,

W. Blair Stewart, M.D.

President Lippincott: You have heard the report of this Committee, what is your wish? A motion for acceptance would be in order.

Dr. J. F. Hagerty: I so move.

The motion was seconded, put to a vote and carried.

President Lippincott: Report of the Com-

mittee on Revision of the Constitution and By-Laws.

Dr. Frederic J. Quigley: The Committee on Constitution and By-Laws offers for adoption the following amendments to the Constitution, to be accomplished in conformity with Article XII. These amendments were submitted in writing and read at the last Annual Meeting.

This statement is correct except in one particular. You will recall that there was a proposal last year that the Constitution and By-Laws be amended to provide for a *President-Elect,* and there were 3 amendments offered to the Constitution affecting that proposal, and half a dozen or more changes were adopted as amendments to the By-Laws. Through inadvertence, one of the *articles,* the first I will read, was not submitted in writing; however, it all has to do with the same subject and it was properly printed in the April and May issues of the Journal.

The Committee would like, also, to give its interpretation of the effect of the adoption of these amendments regarding a President-Elect. The proposal was that the Society should, after adopting the change, elect a President-Elect, a First Vice-President and a Second Vice-President, and that the President-Elect should in the following year himself succeed automatically to become President. In the event of the adoption of these amendments today, it is the feeling of our Committee that it will be necessary for the Nominating Committee to nominate, and for the Delegates tomorrow to elect, a President-Elect and a President both, because there is as yet no President-Elect automatically to succeed himself.

So, the Nominating Committee today will nominate First and Second Vice-Presidents, a President-Elect and a President, and the Delegates will elect these 4 officers tomorrow in the event of a previous adoption of these amendments.

Next year, and in subsequent years, whoever is then President-Elect will succeed himself for the following year without process of nomination and election.

I will read the report through and then go back and take up the various *articles* and *sections* one by one.

Report of Committee on Revision of Constitution and By-Laws

To the House of Delegates:

The Committee on Constitution and By-Laws offers for adoption the following amendments to the Constitution, to be accomplished in conformity with Article XII. These amendments were submitted in writing and read at the last Annual Meeting (1932).

SUGGESTED AMENDMENTS TO THE BY-LAWS

After extended debate at the last Annual Meeting (see pp. 7-12 Official Transactions 1932) the question of a more suitable time for the meeting of the Nominating Committee was referred back to this Committee, for "report at the next Annual Meeting".

This Committee is of the opinion, that the evening of the first day of the Meeting would be a more suitable time for the Nominating Committee to meet; and, so as to accomplish this, we offer the following:

(Explanation: The Nominating Committee would then meet at 8.30 p. m. the first day of the Annual Meeting, instead of at the close of the afternoon session.)

This Committee recommends that the following Special Committees be made Standing Committees: (1) Committee on Medical Defense, (2) Committee on Health, Life and Automobile Insurance (to be re-named Committee on Insurance).

"*Section 13.* The Committee on Insurance shall consist of 7 members, appointed annually. It shall arrange, with carriers, for various types of insurance, except professional liability, to be available to members, and covering particularly Health, Accident, Life and Automobile. It shall supervise the application of such insurance to members of the Society."

The foregoing proposed amendments to the By-Laws to be accomplished in conformity with Chapter XV.

Respectfully submitted,

Frederic J. Quigley
George H. Lathrope
J. B. Morrison

If there is no objection, Mr. President, I will now take up those amendments one by one.

Article IV. Section 1. (p. 6) Strike out the entire wording and substitute: "This Society shall be composed of Fellows, Officers, Delegates and Members of Component Societies in good standing."

Mr. President, I move its adoption.

The motion was seconded, put to a vote, and adopted.

Article IV. Section 2(b). After the comma following the word *President,* delete the words *"three (3) Vice-Presidents"* and substitute the words "a President-Elect and two (2) Vice-Presidents".

I move its adoption, Mr. President.

The motion was seconded.

Dr. William F. Costello (Morris County): May I ask for information as to the purpose of this amendment, and in what way it is going to increase the efficiency of the organization? I would just like some further information before we vote on it.

Dr. Quigley: This amendment was brought up by Dr. Lathrope 2 years ago. The thought was, as I have explained, that it was in conformity with the trend of the times in most State and National organizations—to have a

President-Elect, one who would be trained to step into the presidency. There is no other thought than that in proposing this change.

Dr. Samuel A. Cosgrove (Hudson County): It doesn't seem to me, Mr. President, that the proposed amendment insures any better training for the incumbent, who will pass along to the presidency, than does the system that we have always worked under, and where, in the normal course of events, the directly elected President has already received 3 years of successively intensive training. On the other hand, it is a departure from democratic principles, and the principles that have always guided this Society, in that it robs the House of Delegates of a certain freedom of selection of its officers, and virtually elects a single individual to office for a 2-year period. That is, the mandatory succession of the President-Elect to the presidency virtually constitutes electing a person, the same individual, to a succession of offices for a 2-year period, which is a departure from everything that the history of this organization has represented in the past.

Dr. E. J. Marsh (Passaic County): Mr. President, may I say a word about this suggested amendment? Last year I spoke in opposition to it, being a little doubtful about the suggestion, but I have been thinking it over during the past winter and I think it has considerable advantage. Of course, we have always had Presidents-Elect, because a President-Elect is simply a man who is elected but not yet in office. You, yourself Sir, were last year virtually President-Elect for 24 hours, but we didn't call you that. If this method goes into effect, we probably will tomorrow elect 2 Presidents at the same time. We will have 2 Presidents-Elect, 1 for 24 hours and 1 for a year and a day. Not only that, we will elect 2 Fellows at one time, because the Charter says a Fellow is a person who has been elected President. Election as President constitutes one a Fellow. Therefore, assuming that Dr. Ely will be elected President-Elect tomorrow, he will be able to say—"I am a Fellow",—a whole year earlier than the rest of you Fellows who are now Associate Fellows. But, so much for that.

Of course, the point has just been raised by Dr. Cosgrove that you elect a man a whole year in advance and you don't know how he may turn out. Dr. Morrison pointed out to us last year, when that suggestion was made, that the Board of Trustees always has authority under the Constitution to order an officer, who is suspected of being neglectful of his duty, before a General Court-Martial, to be sentenced to death or such other punishment as the Court-Martial might order, but we know perfectly well that any man who is chosen by us as President-Elect is not going to do that sort of thing.

I rather envy Dr. Ely, in a way, assuming that he is going to be chosen President-Elect, that a year from now he will have the satisfaction which comes to any man with a good conscience, of saying: "Now, here, I have been President-Elect for a year. I might have laid down on my job, but I didn't." We know how that sort of thing makes us cheerful and pleased with ourselves.

Dr. F. W. Pinneo (Essex County): I wish to speak in favor of this Committee report, which is the result of not only the committee's own study but discussion by the House of Delegates last year. An active year for the President-to-Come is the year preceding his presiding. I think Dr. Ely, if he is to be elected our next President, will find it a satisfaction to know during this year of preparation before his presiding that he is known to others as—*the next President*. It is not only the A. M. A. form, but that of our own Academy of Medicine in Northern New Jersey. From the fruits of experience, the Academy elects a President for 2 years. I hope this will carry.

President Lippincott: Is there any other discussion on this subject?

The *question* was called for.

Dr. Quigley: Mr. President, I move the adoption of *Article IV, Section 2(b)*.

The motion was put to a vote and, as there was a *division* called for, a rising vote was taken; and the motion was carried by 73 voting in favor and 33 opposed.

President Lippincott: The motion is carried.

Dr. Quigley: *Article IV. Section 3(c)*. Strike out the entire subsection. The reason is that certificates signed by officers of component societies accrediting Delegates are unnecessary because each Delegate is accredited by a certificate issued by the Secretary of the Medical Society of New Jersey.

I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IV. Section 3(d)*. Strike out the word *"a"* in the second line.

I move the adoption of this amendment.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IV. Section 3(d)*. Change to sub-sections (c) and (d) respectively. The explanation is, that re-lettering of

the sub-sections is made necessary, as a result of the deletion of sub-section (c).

Secretary Morrison: I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IV. Section 3(f).* Strike out the word *"his"* (last line on p. 8, last word) and substitute the word *"an"*. The purpose of this proposal is to permit any Alternate Delegate to take the place of any Delegate unable to attend, rather than requiring a particular Alternate for each Delegate.

Dr. Stahl: I move it be adopted.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IV. Section 4.* Strike out entire wording and substitute: "All members of Component Societies in good standing are hereby constituted members of this Society, and entitled to participate in all the privileges of general and scientific sessions."

I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article VI.* (p. 10, first line). Strike out the words *"three (3)"* and substitute *"President-Elect and two (2)"*. I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article VIII. Section 2.* After the word *"Delegates"* (first line of section) and before the word *"may"*, insert the words *"or the Board of Trustees"*.

So, if circumstances make it advisable between meetings of the Society, to create a new Section for scientific work, the Board of Trustees is authorized to create such section or sections.

I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IX. Section 2.* Strike out the numeral *"3"* (fifth line of section) and substitute *"President-Elect and two (2)"*.

I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *Article IX. Section 2.* At the end of the first sentence, replace the *"period"* with a *"comma"*, and add the following: "except that the President-Elect shall succeed to the office of President without process of nomination and election".

I move its adoption.

The motion was seconded, put to vote and carried.

Dr. Quigley: Mr. President, we offer the following amendments to the By-Laws: First, to make the meeting of the Nominating Committee *in the evening,* which it is felt will be a more suitable time. The Nominating Committee members, after the close of the first session, are apt to be tired, and this plan will give them an opportunity for a little exercise on the boardwalk, and perhaps a meal, and they could come back in the evening better prepared for the work.

Amend *Chapter V, Section 1,* by deleting, in the first and second lines of the last paragraph, following the word *"at"* and before the word *"the"*, the words *"the close of the afternoon session on"*, and substitute *"8.30 p. m."*. I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: We recommend that the Special Committees on Medical Defense, on Health, and on Life and Automobile Insurance (to be re-named *Committee on Insurance*) be made Standing Committees.

Amend *Chapter VIII, Section 2,* by adding immediately under the words *"Hospitals and Medical Education"* the words *"Committee on Medical Defense"* and immediately under these words *"Committee on Insurance"*.

I move its adoption.

The motion was seconded by Secretary Morrison, put to a vote and carried.

Dr. Quigley: Amend *Chapter VIII* by renumbering Sections "12, 13, 14, 15, 16" as "14, 15, 16, 17 and 18" respectively.

This was made necessary by creation of the 2 new sections. I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: Amend *Chapter VIII,* by creating 2 new sections, "12" and "13", as follows:

"Section 12. The Committee on Medical Defense shall consist of 5 members, appointed annually, and shall have charge of all matters pertaining to alleged malpractice by members. It shall maintain contact with the Judicial Council and refer questions of an ethical nature to that body." I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: *"Section 13.* The Committee on Insurance shall consist of 7 members, appointed annually. It shall arrange, with carriers, for various types of insurance, except professional liability, to be available to members, and covering particularly health, accident, life and automobiles. It shall supervise the application of such insurance to members of the Society."

Mr. President, I move its adoption.

The motion was seconded, put to a vote and carried.

Secretary Morrison: I move, Mr. Chairman, we adopt this report as a whole.

The motion was seconded, put to a vote and carried.

President Lippincott: We will now hear the Annual Report of the Secretary.

Secretary Morrison read his prepared report, as follows:

Annual Report of the Secretary

To the Officers and Members of the Medical Society of New Jersey: We open today the 167th Annual Convocation of our ancient and honorable Society. We are proud to report that it is yet, in all its activities, out-standing among the leading State Medical Societies.

This House of Delegates, based on the Official List of 1932, should consist of a membership numbering 188: Elected Delegates, 151; Trustees, 17; Fellows who at present are not Trustees, 9; Members of the Judicial Council who are not elected Delegates, 1; making the total of 188.

I would advise the Secretaries of the Component Societies present to make an inquiry as to the reason for so many absentees at this session.

Our total membership, Dec. 31, 1932, was	2852
Names on the Official List, April 1, 1932	2612
Names on the Official List, April 1, 1933	2750
New and re-instated members since that date making a total Active Membership at this date of	90 2820
Associate Members elected during the year	82
If we have the normal rate of increase this year, our total by December 1933 should be approximately	3000

It was feared by your officers that this continued depression would have a marked effect upon our total registered membership. Instead of any reduction, however, we went to press with the Official List containing the largest membership of any April 1 publication period since I assumed the duties of your Secretary.

We have lost by death, 44 members. Among these was one who long had been our oldest living Ex-President—Dr. Thomas J. Smith, of Cumberland County. Dr. Smith outlived the term of his Presidency by 35 years, and also outlived 21 of those who had succeeded him as Presidents.

Among the deaths which we sincerely mourn was that of Dr. William G. Schauffler, of Mercer County. An erudite, cultured, polished gentleman, "a Doctor of the Old School", he occupied the chair of President of this Society in 1917 but spent most of his presidential year in France, serving his country during the Great War. As a former member of our Board of Trustees, as a member of the Welfare Committee for many years, and a member of several Special Committees, his services to this Society, and to the medical profession in general, were invaluable. Among those who attended his funeral services in Princeton was his old friend, Dr. Henry A. Cotton, Medical Director Emeritus of the State Hospital, in Trenton, and who derived considerable fame in advocating the infection causation theory of insanity. In less than 2 weeks Dr. Cotton joined Dr. Schauffler in the Great Beyond.

Another deeply mourned death was that of Dr. Martin W. Reddan, of Mercer County. Dr. Reddan was one of our Board of Trustees and for many years was Chairman of our Committee on Arrangements. He was a prominent citizen and surgeon in Trenton and that entire community honored his memory at the funeral services.

In the death of Dr. Emanuel D. Newman, of Essex County, this House of Delegates lost a very valuable member. I recall that 10 years ago it was Dr. Newman who induced me to accept the office of Secretary of this Society. He was a member of our Business Committee for many years, and he was largely instrumental in founding the Academy of Medicine of Northern New Jersey.

Dr. George L. Mack, of Somerset County, had been one of our valuable Delegates for many years.

During the year, I have made 20 visits to 15 Component County Societies and it was only because, as a matter of forced economy for the Society, that it became necessary to curtail the expenses of my office, or I should have been with you all at least once, as usual. I trust that next year I may be in a position to visit all the Component Societies as heretofore.

There are a few matters in connection with the Component Societies to which we must refer. The names of new members received from the Treasurer of the State Society between February 1 and March 7, for the Official List, are not forwarded to the Biographic Department of the American Association prior to publication of the list. Were we to do otherwise it would incur considerable expense. I have only a half-time stenographer for all my office work, and at the time of preparation of the Official List the work is very heavy. However, this year, because so many new members were clamoring for the Journal, since all these far-reaching and important economic questions were under discussion, we made out a list of some 380 new and re-instated members, and sent them to the American Medical Association, and to the Publication Committee so that they might be added to their mailing lists.

May I again call to the attention of the Secretaries that if an Honorary Member in any Component Society wishes to remain in active practice and enjoy the various protection services we have to offer, the Component Society of which he is a member must remit his dues to the State Society to our Treasurer.

Since we adopted the amendment to the Constitution creating a class of "Associate Members" the names of Associate Members in the Official List must in the future be limited to this class. Most of our Component Societies carry a list of complimentary names as Associate Members. These in the future must be given some other appellation, such as "Non-Member Associates" or "Visiting Associates", and I trust that this body will adopt by resolution some suitable name to be used for these Associates for the sake of conformity.

The plan for the Certification of Specialists has been held in abeyance by the Committee of the State Society, pending some further action by this body. The Report on the Costs of Medical Care has been published since we last convened. Perhaps no other document published in America since the abolition of slavery has created such wide-spread interest and discussion. Committees have been formed in most of the Component Societies to study this *"Report"* and to forward their conclusions to the Special Sub-Committee of the Welfare Committee handling this matter, so that this body may formulate some concrete opinion to be

forwarded to the American Medical Association as our stand with regard to the *Report*.

We are undoubtedly at the end of that era in medicine which has lasted almost since "the dawn of medicine" and are at the birth of a new era. What course it will take, what innovations and changes will be introduced, and what effect they will have upon our profession rest largely in our own hands, if we but determine to guide this movement from its inception. On Wednesday evening we will have 2 Guest Speakers to discuss with us these economic trends in medicine.

An effort is being made by the National Boards of Medical Examiners to exclude from the practice of medicine in this country, the young men who go abroad to study medicine in other countries where the preliminary educational and scholastic requirements are below the standards required in America.

Those students are allowed to graduate in medicine in these foreign countries but are not licensed to practice there, in the countries where the universities have granted the diplomas. This year more than 2000 such students are studying abroad. In the month of March, I received a communication from The Travel Department of the American Express Company, asking what action, if any, the Medical Society of New Jersey had taken in reference to this matter. I replied that it was under advisement and would be taken up at this session of our House of Delegates. I trust you will take some action.

I am pleased to be able to report that the Medical Society of New Jersey stands at the top of the list at our headquarters in Chicago in the number of members who have this year renewed their subscriptions to the Journal of the American Medical Association; 74% of our members having so subscribed. Connecticut stands next with 65%, while New York had fallen to about 60%, if my information is correct.

May I call your attention to the amendments to the Constitution and By-Laws which will be offered for adoption at this session. If and when they are adopted, I trust that the Secretaries of the various Component Societies will acquaint themselves with the new requirements.

Respectfully submitted,

J. B. Morrison, M.D.,
Secretary.

President Lippincott: What is your wish with regard to the report of the Secretary?

Dr. Quigley: I move it be received and placed on file.

The motion was seconded, put to a vote and carried.

President Lippincott: We will refer it to the Business Committee. Now, Dr. Carrington, have you a report to make for the Committee on Credentials?

Report of Registration Committee

Dr. William J. Carrington (Atlantic County): The registration is, so far, as follows, by counties:

County	Delegates	Members
Atlantic	8	11
Bergen	5	4
Burlington	3	0
Camden	2	2
Cape May	0	0
Cumberland	2	0
Essex	43	4
Gloucester	3	0
Hudson	12	2
Hunterdon	1	0
Mercer	5	2
Middlesex	2	1
Monmouth	1	2
Morris	5	3
Ocean	0	1
Passaic	5	1
Salem	1	0
Somerset	2	0
Sussex	1	1
Union	14	3
Warren	2	2
	117	39

In addition, there are 29 exhibitors and 104 guests, making a total registration, up until 20 minutes ago, of 289.

Final Report of Registration Committee

Delegates, Members, Guests and Visiting Doctors attending the Convention of the New Jersey State Medical Association, Chalfonte-Haddon Hall, Atlantic City, June 6 to 9 inclusive:

Counties	Delegates elected	Delegates registered	Members registered	Guests registered
Atlantic	7	9	68	91
Bergen	9	10	9	9
Burlington	3	6	7	8
Camden	10	8	31	29
Cape May	3	3	3	1
Cumberland	3	2	11	6
Essex	42	52	36	38
Gloucester	3	3	9	13
Hudson	24	24	15	30
Hunterdon	3	2	0	2
Mercer	10	9	22	22
Middlesex	9	4	11	5
Monmouth	2	3	12	12
Morris	2	5	9	5
Ocean	3	3	3	10
Passaic	16	9	7	5
Salem	3	2	2	4
Somerset	5	5	8	15
Sussex	2	1	2	3
Union	14	17	24	28
Warren	2	& 2	3	& 6
		178	292	342

Visiting Doctors	51
Exhibitors	38
Delegates	178
Members	292
Guests	342
Total	901

Respectfully submitted,

Mrs. H. J. Hedlund,
Atlantic City, N. J.

President Lippincott: You have heard the report of the Committee on Credentials. What is your wish?

Secretary Morrison: I move it be accepted and placed on file.

The motion was seconded, put to a vote and carried.

President Lippincott: Dr. Reik, are you ready to present your report as Editor and Executive Secretary?

Annual Report of the Editor and Executive Secretary

(1) Custom requires of us the presentation of an Annual Report concerning such of the affairs of the Medical Society of New Jersey as have been entrusted to our care, supervision or performance.

It has been for some of us, especially the trio comprising the Editor-Executive Secretary, Field Secretary and Office Secretary, an extremely busy year. Whatever may be said about *unemployment* in general, we can assure you there have been no idle hours for us, and neither slackness of service nor lack of employment in our respective offices.

In a few months we shall have finished 9 years of service with this organization as Editor of your Journal and Executive Secretary of this State Medical Society. At the inception of that service somebody remarked that if our planned work-schedule should ever become fully operative its director would be "the busiest man in New Jersey", and, as a matter of fact, that goal seemed to have been reached in the course of the first 3 years, but we have gone on developing and reaching out into attractive by-ways to take on new tasks, until we have exceeded the possibilities of any 1 or 2 individuals properly to perform.

Our 2 assistants, Mrs. Taneyhill and Miss Mahoney, have been quite remarkable "finds", and much credit is due to them for their share in our achievements. In consequence, however, of the growth of our labors, we are compelled now to request an addition to the personnel; an office assistant to Miss Mahoney, the cost of whose services will probably be $20 per week.

After a brief period of direct association with us, to receive such training as we were capable of giving, and another time period of coöperation in experiments *to determine what the public most needed* in the way of education concerning medical matters, *and how that need might best be met*—with the greatest benefit to the people and with the least disadvantage to the profession, Mrs. Taneyhill chose what she believed to be the most promising field for intensive cultivation. With the aid of Dr. Ireland, Medical Director of the State Board of Education, she set up an excellent Public Educational Program; a program which redounds to the credit of this Society. In addition to her other special qualifications she has shown remarkable aptitude for that type of work and during the past year we have received, entirely unsolicited, letters commending her work from nearly every County Superintendent of Schools; and most of those Superintendents have requested return engagements for the coming year.*

The value of her services to the physicians of this State can scarcely be exaggerated. For 2 years past, while technically under direction of the Executive Secretary, and reporting to him regularly and at least once a month, she has been practically entirely "on her own" and, consequently, deserves in full whatever meed of recognition and praise may be accorded to the success of that program. She will present her own report, and our references to her work are made as introductory thereto, endorsement thereof, and thanks therefor. At the same time we wish to take advantage of the opportunity to express our personal thanks and the thanks of the organization to Dr. Ireland for all he has done for the State Society. There then remains only, regarding this matter, to say that we hope nothing will be done here which might interfere with the continuance of her plans for public education in medical matters; plans which have been built up slowly and with tremendous expenditure of time and labor.

Fairly familiar with conditions in other States, we can assure you that the educational work of this Society far surpasses anything now being done, or that has ever been done, elsewhere; i. e. with reference to the public educational work of our Field Secretary, and the Post-Graduate Courses developed by Dr. Cosgrove's Committee in conjunction with the Rutgers University representatives.

With reference to the Post-Graduate Courses, and the possibility of their continuing, permit me to present a letter recently received from Mr. Clothier, the new President of Rutgers:

"My dear Dr. Reik:

Any words which I might use would be quite inadequate to express to you the sense of gratification which was mine upon reading your cordial letter of April 27. What has been accomplished in the field of post-graduate medical instruction is a tribute to the vision which you and your associates had years ago and we at Rutgers have been happy to have had a share in the work. The response which the members of the medical profession throughout the State have made to the project is eloquent testimony to the integrity of your foresight.

We are proud of the work which the members of our staff under Professor Miller have been able to do and entertain the hope that no curtailment of income will prevent Rutgers from continuing its coöperation with the Medical Society of New Jersey on the same effective basis as has been the case heretofore.

Again thanking you for your splendid letter and with the hope that I may have another opportunity soon to speak with you, I am,

Sincerely,

(Signed) Robert C. Clothier,
President, Rutgers University."

Public Relations. From this we are led, naturally, to speak of other organizations with which we have developed associations. That list includes: the State Board of Medical Examiners; State Board of Health; State Board of Education; State Department of Institutions and Agencies; Tuberculosis League; State Association of Pharmacists and Dentists; State Social Service Conference; Society of Chiropodists; Rutgers and Princeton Universities—with all of which groups we are now upon the best of terms.

You have been told, incidentally, how we chanced to establish important relations with Princeton University and with that Faculty member, Prof. Dodds, who has just recently been elevated to the Presidency vacated by the death of the late John Grier Hibben. Recording this event brings to mind, in turn, our irreparable loss in the death of our

most beloved colleague, *William Gray Schauffler,* "whose like will never again be seen".

Legislation, State and National. Only yesterday, June 5, we witnessed Governor Moore's signature to the recently enacted "Uniform State Narcotic Law", differing in a few details only from the law as drafted under supervision of and approved by the American Medical Association.

Nationally, we participated in the effort to correct the evils that had grown from excessive Governmental sympathy for Veterans whose illness or injury was not *service-connected,* and we thanked President Roosevelt, in your name, for his good work in that respect.

"To the President of the United States,

Honorable Franklin Delano Roosevelt,
Washington, District of Columbia.

My dear Mr. President:

The Medical Society of New Jersey, comprising twenty-eight hundred (2800) physicians and surgeons, many of whom are Veterans and Legionnaires who served with the A. E. F. in France, protests continuance of National Governmental care or treatment and hospitalization of World War Veterans whose injuries, diseases or illnesses, are *not service-connected.* We respectfully urge revocation of such laws as are now favoring and supporting the claims of so many so-called Veterans unjustly clamoring for Governmental support.

We are heartily back of you in the plan already started with the object of curtailing other false claims upon the National Treasury.

Respectfully yours,
Henry O. Reik, M.D.,
Editor and Executive Secretary."

Inasmuch as the State Legislature is still in session, it is too early to present a conclusive report, but we can say that as yet we have suffered no reverses.

American Medical Association. Some of you may have noted in the Pre-Sessional Reports of our national organization, that New Jersey is one among the total number of States (7) which has a Component Medical Society in every County in the State; and further, that our State Society stands at the very top, with a record of 74% of its members subscribing to the Journal of the A. M. A., and thereby being listed as "Fellows" of the American Medical Association. Our nearest competitor was New Hampshire with 66%—a considerable gap.

Final Report of the Committee on the Costs of Medical Care. The National Committee made its Report public on November 29, 1932, and since that date it has been almost the only topic of discussion among the physicians.

The January Journal was the largest monthly issue we have ever put out, but in that Journal, the members of this State Society had put into their hands in readable, though in abstract, form, all of the essentials that were in possession of the members of that National Committee when they drew their conclusions and recommendations. We have explained in other issues of the Journal what that meant, why the January Journal was used in that manner, and how the results were even more satisfactory than was anticipated. It was a pleasure to follow up the other State Society Journals, to observe what they were doing for their members, and I repeat now that the members of this organization, without any cost to themselves individually or to themselves as combined in the State Medical Society, have received more clearly explained information on that particular topic than has been given to the membership of any other State Society in this country.

In the April issue of the Journal we reported, in so far as was then possible, what had been done or was being contemplated in other State Societies, and the manner in which our County Societies were meeting the situation. The Editor has been both blamed and praised for the articles published in the January Journal. One individual, a signer of the *Minority Report,* addressing one of our County Societies, made the statement that this Editor should not have been permitted to publish his paper regarding conditions under National Health Insurance in Great Britain. That has been the attitude of a part of the medical profession during the past few years, preferring to remain ignorant of what is happening in other places and simply to denounce so-called *state medicine.*

Next, was criticism by a member of this Society, who scored us for *not having assumed leadership,* and for not having advised our members, through the editorial columns of the Journal, what action should be taken with regard to that Report; despite the fact that the editorial which accompanied the abstract report of the National Committee's work gave reasons why the Editor of a State Society Journal should not express personal opinions until after the organization had determined a policy and that it was up to the State Society to prepare such policy and give it due publicity.

The third referred to a meeting of one of our Councilor Districts when the Editor had the privilege of sitting next to the Guest Speaker of the evening and heard him make this statement in the course of his address: "I tell you, no matter what anybody says about physicians being satisfied with the national insurance law in England, it is not true." A large percentage of the audience on that occasion had in hand, of course, the Editor's letter published under the title "a child sat among them taking notes", and it was a very specific and direct denunciation of our views and a declaration that the truth was not in us. Yet at almost that very same moment a distinguished physician from London was addressing the New York State Association and telling them just how well the physicians of England are satisfied with that law and how they have pending in Parliament at the present time an appeal to have the law extended; i.e. to cover in a greater part of the population of the country, and to amplify the service so as to provide for specialists and for hospitalization.

We hold no plea for state medicine or national health insurance but we do believe, very strongly, that at the moment when this problem requires serious consideration, it is desirable that those who are going to determine the policy of the profession shall be possessed of all available information bearing upon that problem. In our opinion, the January Journal is an excellent example of how such publications may serve as educational factors.

Annual Conference of County Society Secretaries and Reporters. This conference, now well established, is of tremendous benefit to the State Society and has been of value to a number of the County Societies themselves. It is a matter which should not be left out of our arrangements for the coming year; certainly not on the basis of economy, of all things. The knowledge distributed, and the coöperation brought about among the officers of our various County Societies in preparation

for their work as component parts of the State Society, are certainly worth $150 per annum.

Tri-State Conference, concerning which even more might be said as to its value, is an informal organization of the officers of the 3 State Societies, New York, Pennsylvania and New Jersey, which holds 3 sessions per annum, where problems of the sort just mentioned a few moments ago are considered by the men who must act for the individuals who compose those societies. They never take specific action further than to report to their respective societies what suggestions or recommendations such a Conference may have made.

The Woman's Auxiliary to this organization has been of increasing value. During the Winter, an appeal was made to the President of the State Society by the President of the Woman's Auxiliary for information as to what the Auxiliary could do for the medical organization. Having asked the question as to whether it would be wise to follow some of the suggestions previously offered by the Editor, and particularly with reference to that of acting upon the false and misleading advertisements in our newspapers and magazines, and collaterally, perhaps, in reference to the pure food laws of this State, President Lippincott appointed a Special Committee to confer with the Auxiliary in that matter. What shall come out of this will not depend on the suggestion from the Editor, or its approval by the President of the Society, but upon the coöperation that is afforded to the local County Auxiliaries by the local County Society Officers and members. *With your assistance, the Auxiliary can do work of great value to the State Society. Without your support and assistance,* it can accomplish very little.

Arts and Hobbies. This is a new topic for consideration. President Lippincott, in response to our solicitation, appointed a Special Committee on Arts and Hobbies, with Dr. Campbell of Long Branch, as its Chairman, with the object of arranging for an exhibit during this session of the State Society to show what some of our members do; what they have in the way of a *hobby;* what they may be capable of doing in the line of *art,* using that particular word—art—in its broadest sense. The idea is not entirely original, of course, for similar plans have been in operation in the State of New York for several years. Our latest information is, however, to the effect that there has been a marked response and that the committee will have for your delectation and edification a very satisfactory exhibit—running from oil paintings down to ordinary black and white photography, still or movies, and including, under the name of *hobbies,* the collection of Indian relics, coins, stamps, and one thing or another.

The Journal, we think, now speaks for itself, and it is for you to judge whether or not it has earned your support and approval, and whether it shall be continued in the manner heretofore developed by the present Editor.

Specialism. This Society, having considered and adopted the proposition presented by Dr. E. G. Waters, of Jersey City, turned it over to the retiring President, Dr. Hagerty, for development. He had, during his presidential year, discussed the matter at various meetings; at a Personal Luncheon of representative leaders in the State Society; at the Annual Conference of Secretaries and Reporters of County Societies, with the Board of Trustees; and, before the Welfare Committee; meeting with universal approval. Only once, and that was when the Society voted on adoption of the plan at the last Annual Meeting, was there any opposition; and then only 1 member of the Society voted against it.

When, however, it came time for Dr. Hagerty to put the plan into operation, after smooth running for a few months, he struck a snag. Objections were made, particularly in our 2 larger societies, Essex County and Hudson County, and that brought about at once a suspension of action. Those who advocated the Waters' plan never had any desire to act upon the basis of "star chamber" proceedings; had no desire to injure or hurt anybody; desired, really, only to look after the health interests of the public in the matter of recognizing specialists, and to look out for the interests of the State Society, incidentally, because we are, as an organization, necessarily held responsible for the acts of our members.

I imagine that neither Dr. Hagerty nor Dr. Waters considered that plan absolutely perfect. But, if it be imperfect—instead of killing it, as has been suggested might be done here at this meeting—why not make an effort to improve it? This is the first State Medical Society, so far as I can ascertain, that has taken any definite action in line of governing the acts of those who miscall themselves *specialists.* I think that is a creditable action, and to the glory of the organization.

One medical organization, but not a State Society, has actually put into operation a similar plan, that is, the plan introduced by Dr. John A. Hartwell to the Academy of Medicine of New York when he was President of the Academy and proposed such a plan in his Presidential Address. That was 3 years ago. His plan has since been put into effect and I have very specific information, obtained during the past month, that it is working there very satisfactorily. I know also, from several conversations with Dr. Hartwell, that he desires to see it extended to the New York State Medical Society. I know further, that at a recent meeting of the Tri-State Conference, Dr. Rappleye, Dean of the Medical School at Columbia University College of Physicians and Surgeons, made the statement that *he envied the New Jersey State Medical Society, having been the first to work up such a plan,* and adopt it, and prepare to utilize it; and for the reason that he had tried in vain for several years to get it properly before his own State Society.

Furthermore, at the last meeting of one of the American Medical Association's important groups, the Council on Medical Education and Licensure, announcement was made that the American Medical Association had at last devised a similar plan believed to be applicable to any or all the States. Dr. Morrison has suggested that it was the action of this State Society that brought the American Medical Association into such newly displayed activity.

The point we would at present make is that the New Jersey State Society has dealt with this problem, has presented a specific plan, and desires to have it tried out. If the American Medical Association's plan is, as we stated in answer to Dr. West's report, better than that of our own Society, it will doubtless be adopted here. May we, therefore, suggest that, in view of the facts just stated, this Society should proceed with its own plan? Don't throw away the credit this organization has won, simply because there may be some 1 or 2 features of that proposition which need to be changed. We are not making a report for the Committee, but simply asking you to treat the plan fairly and con-

siderately, and act upon it according to its merit. If it is defective, improve it. It is easy enough to amend such a proposition, but don't throw this plan away without having given it proper consideration.

We do not know what is coming in the report of the Committees on so-called *State Medicine*. We know that 2 Committees have been formed. One appointed 2 years ago has not been very active. One appointed recently by the Welfare Committee has been studying the problem, and has encountered the same sort of situation as developed in the National Committee, namely, that there will be 2 reports, a *majority* and a *minority* report, submitted. We can't all be alike, but we can all be fair in dealing with these propositions.

On Wednesday night you will have the privilege of hearing Dr. Ross, an Ex-President of the New York State Society, who probably has given as much time and consideration to these problems as any other man in the country. I don't know what he is going to say, but I do know he once made this statement: "If and when *state medicine* actually faces us, there are 3 possibilities. We can ignore it and take what comes to us; we can make a retreating fight with a covering rear guard, and drop back from post to post; or, we can treat it in a courageous manner, study and deal with the problem according to the demands made."

What about these demands? We know some of them are honest and should receive attention. Let us supply the public with a proper response to such of their demands as the people make, for we can thus forestall any adverse legislation.

Respectfully submitted by

Henry O. Reik, M.D.

***Does the Educational Work of the Medical Society of New Jersey Get Across?**

What People Are Saying About It to the Field Secretary and Others

Mr. J. M. Arnold, Mercer County Superintendent of Schools:

"I want to thank you for the help that you have given us and to tell you that your talks were very fine."

Jeanne M. Wright, Dean of Girls, Princeton High School:

"I want to thank you again for the splendid talks you gave here last Wednesday. I cannot begin to tell you how many nice things I have heard about you. Our students are still referring to many of the points you made."

Mr. A. D. Schultz, Chairman Program Committee, Keyport Kiwanis Club:

"The information has come to me that your talk before the Kiwanis Club of East Orange was one of the outstanding talks of the season. I am writing to inquire whether it might be possible for you to speak at our club sometime in the near future."

Dr. Dorothy Lottridge, Medical Inspector, S. Orange and Maplewood Schools:

"May I express my appreciation of the services you have just given in the schools of Maplewood and South Orange? The principals of the schools you visited were more than pleased with your talks. Hope you may be with us again next year."

Dorothy LaSalle, Director of Health and Physical Education, East Orange Public Schools:

"We were more than glad to have you in the East Orange schools and appreciate tremendously the work you are doing and the service you are rendering."

Helen R. Rouse, Director Health and Physical Education, Ventnor:

"After your excellent talk to the children on 'Foods', I called Mr. Haverstick, President of the Ventnor Parent-Teacher Association, telling him how the children enjoyed every word, and asking if it would be possible to have you talk at one of our association meetings. He was at once very enthusiastic, remembering your former visit, and asked me to write and find out whether it would be possible for you to talk at the regular monthly meeting Thursday evening, March 16. The children have spoken of you many times, and I hope their parents may also have the pleasure of hearing you again."

Hazel M. Smith, Principal Ventnor Avenue School (to Dr. Lippincott):

'On Wednesday, February 1, we were given the opportunity of having Mrs. Ethel Taneyhill talk to the boys and girls of grades seven and eight, her subject being 'Food Value'.

As usual, she was met with a hearty pupil response that practically amounted to an ovation, for the students always enjoy her and profit by what she tells them. Some even asked for printed copies of the speech, to take home to their Mothers.

The teachers join me in expressing to you our appreciation of the very valuable work that Mrs. Taneyhill is doing, and the hope that such work may be continued for us."

Mrs. J. R. Rodie, Secy. P.-T.A. of Union Street School, Ridgewood:

"The Parent-Teacher Association of Union Street School wishes to thank you for the informative talk which you gave at the meeting of March 20th. Your interesting delivery, brimful of sound instruction, was very helpful. We appreciate the opportunity of having you, and hope your name will appear again on our program."

William W. Reynolds, Principal Haddonfield Memorial High School (to Dr. Lippincott):

"May I express the appreciation of the members of the faculty and student body of our High School for the thoughtfulness which the Medical Society shows in giving us the privilege of listening to addresses given by Mrs. Ethel C. Taneyhill."

Arthur E. Chase, Supervising Principal, Borough of Fort Lee:

"I am sorry that an unexpected matter prevented my hearing your talk on 'You Are What You Eat', given in our High School auditorium on March 24th. The teachers who were so fortunate as to be present said it was excellent and was much appreciated by the pupils."

Nelson C. Smith, Supervising Principal, Leonia (to Dr. Ireland):

"Your Mrs. Taneyhill addressed assemblies in our High School yesterday and today. I wish

to thank your department for any part you may have had in allowing Mrs. Taneyhill to make these addresses in our schools.

"She is a most pleasing speaker and gives the pupils something thoroughly worthwhile, presenting the material in a way that makes a real appeal to the young people. We shall hope very much to have her again in Leonia."

V. C. Brugler, Supervising Principal, Hackettstown (to the County Superintendent of Schools):

"I wish to tell you how much Mrs. Taneyhill's recent address on 'You Are What You Eat' was appreciated by our pupils and our faculty. Mrs. Taneyhill has evidently made careful research along the lines of her subject and she presents a very clear, helpful, convincing address."

Will G. Atwood, County Superintendent of Schools, Belvidere (re letter quoted above):

"I am enclosing a letter, received from Mr. Brugler, which explains itself. To this I want to add that from each place where you have talked I have received favorable reactions from the principals, which are just as appreciative as Mr. Brugler's letter, or even more so. I want you to know that we do appreciate the work you have been doing in Warren County."

Lillian F. Lauler, Principal Freehold High School (to Dr. Ireland):

' Wish to tell you how very much pleased we were with Mrs. Taneyhill's address on 'You Are What You Eat', given in our assembly this morning. Over 700 members at the school were crowded together in an assembly which gave its undivided attention to her during her entire address. Interest on the part of the student body was very much in evidence from the beginning to the end. The talk itself was as clear and forceful a talk as I have ever heard, and was decidedly appealing to a High School audience."

Park W. Haverstick, President Ventnor Parent-Teacher Association:

' It was the privilege of the Ventnor Parent-Teacher Association to have Mrs. Taneyhill address the members of our Association at the recent meeting in the Ventnor School Auditorium. The address was well received, entertaining, and delightfully presented by Mrs. Taneyhill. May we express, through you, our thanks to the Medical Society for the splendid message thus brought to us."

President Lippincott: What is your wish, in regard to the Annual Report of the Editor and Executive Secretary?

It was regularly moved, seconded and carried, that the report be received and placed on file.

President Lippincott: The report of the Field Secretary, Mrs. Taneyhill.

Mrs. Taneyhill, the Field Secretary, read her prepared report, as follows:

Report of the Field Secretary for 1932-33

To the House of Delegates of the
Medical Society of New Jersey:

One outstanding development marks the close of the sixth year of the public education project of the Medical Society of New Jersey, namely, its definite acceptance by a large majority of High and Junior-High School Principals as an annual contribution to the health programs in their schools. The proof of this statement lies in the fact that the yearly schedule of the Field Secretary is now practically automatically renewable. Almost without exception the parting words of the Principals are—"We shall expect you next year at the same hour on the same day of the week. Let us know the date."

It has taken 4 years of patient adjusting and re-adjusting of all factors involved to effect this degree of basic organization and even at this stage it is not a rare occurrence to have a Principal say—"We are glad to see you. We have been trying for 2 or 3 years to get a place on your schedule."

There is a wide divergence among schools in the matter of elasticity of assembly hours. Some Principals will forego a talk rather than disturb the fixed order of classes; others will make any concession in shifting schedules rather than lose out on the yearly message from the Medical Society. To anyone who gives the matter any thought at all, it is readily apparent that, in the absence of secretarial help, a quite appreciable part of the Field Secretary's time goes into writing letters based upon consultation with map, calendar and files. Every appointment must first be offered, then confirmed. In cases of conflicting engagements several communications must often be exchanged before an adjustment is reached.

The new talk added to our repertory this year was on the subject of food—"You Are What You Eat"—and it has "gone over" exceptionally well. Its popularity was due in part to the intriguing title, which has received much favorable comment, and partly to the fact that not only physiologically but also economically it was most timely. The points stressed were desirable simplicity in diet, a cutting down of starches and sugar, increase in raw and properly cooked vegetables and, above all, were audiences exhorted to abstain from experimenting with yeast or bran or any other dietary eccentricities except under the guidance of a physician. This talk has been given 146 times, to date, and was pronounced, in one High School, "the most important talk we have had in years". "The Common Cold" has been asked for 28 times, "Medical Quackery and Nostrums" 28 times, "Pasteur" 8 times and "Mental Hygiene" 5 times.

The total number of talks for the year 1932-33 is thus brought to 215. The decrease shown in this figure, in comparison with the total for the preceding year, is more than accounted for by the elimination, at Dr. Ireland's suggestion, of the elementary schools. Several considerations made this step seem advisable: (1) Even the rudimentary knowledge of chemistry which must enter into any discussion of diet is too advanced for pupils below the sixth or seventh grades. (2) The time thus gained would be available to more High and Junior-High Schools than could be otherwise included. (3) The speaker might feel, at the end of the year, more like a human being with some zest still left for her work, and less like a worn out phonograph record, only faintly reminiscent of

its early performance. It should be said here that the results of this revised policy seem to bear out the soundness of the original assumptions.

There has been a noticeable and easily explainable decline this year in the number of State organization and committee meetings. The only gathering of this sort addressed by your Field Secretary was a section of the New Jersey Conference of Social Workers where the talk on "Medical Quackery" was presented by special request. This subject seldom fails to arouse lively interest in audiences of all sorts and ages. At a Faculty luncheon of the Newark State Normal School it was followed by a discussion, on the part of the 40 men and women present, lasting one hour and a quarter, at the close of which we accepted the invitation of the Principal, Dr. Townsend, to return next year and spend 2 days at the school in class room conferences.

County organizations addressed included the Cumberland and Camden County Tuberculosis Leagues and the Union County Council of the Parent-Teacher's Association.

One of the most responsive audiences was found in the Civics Section of the New Century Club of Philadelphia. This invitation was extended through Mrs. A. Haines Lippincott, Program Chairman of the Section, and its acceptance was endorsed by Dr. Lippincott, in view of the large enrollment of New Jersey members. The occasion was productive of several requests for talks to other women's clubs in both New Jersey and Pennsylvania.

The State Normal School in Jersey City was again opened to us for the fourth consecutive year, while the group of some 40 nurses, connected with the schools there, welcomed us back for the fifth time. Acceptance of an invitation to speak to the Alumnae Association of the Jersey City Hospital School of Nursing had to be postponed until next year. The meeting with the 30 nurses of the Metropolitan Life Insurance Company for the Jersey City area formed a new contact which promises to be renewed annually. The usual luncheon and meeting of the Hudson County Auxiliary were greatly enjoyed by the speaker. This is the only Auxiliary which has not missed a single one of the 6 talks comprising our program thus far.

In Essex County the Health Officer of East Orange, Mr. F. J. Osborne, again gave us his wholehearted support. The following excerpt from the minutes of the meeting of the East Orange Health Department, March 2, 1933, will be of interest: "The Health Officer reported that Mrs. E. C. Taneyhill, who was in Essex County from February 6 to 16, under the auspices of the State Medical Society, gave a total of 23 talks, 12 of which were in East Orange, before combined audiences of 11,203—4826, or 43% of which were East Orange school children and others. The Board expressed appreciation for this further evidence of the State Medical Society's interest in public health matters, and was pleased to learn that Mrs. Taneyhill had addressed every public school in the city while here. It was hoped that this service might be continued from year to year."

A luncheon of the Executive Board of the Essex County Auxiliary was followed by a meeting of about 60 members of the organization, where your Field Secretary contributed to a program dealing with mental prophylaxis. In the early Fall the talk on "The Common Cold" was given to an assemblage of 300 teachers and Principals of Maplewood and South Orange. Adding to these groups the East Orange Kiwanis Club and the Verlitsa Club of Verona, we have a record of 27 talks in Essex County this year—an increase of 8 over the previous year and, taken in conjunction with the 2 days promised the State Normal School at Newark, justifying the assignment of 2 weeks for Essex County in 1934. Union County has, for 3 years required annually 10 days, and the rest of the counties are covered in 1 week each, or less. For economy's sake, Warren and Sussex Counties have been combined in an intensive one-week schedule. We very much regretted the necessity of declining the invitation of one of the Helping Teachers to return to Sussex County in April for participation in several Health Week programs. Lack of funds has made it impossible for us to *re-visit* any of the Counties this year.

The 215 talks have reached a total audience of approximately 77,500 individuals. Of these, about 2100 were in adult groups, 3100 were school teachers and principals and the remaining 72,300 were pupils in High and Junior-High Schools. In evaluating the relative importance of these groups one must not yield first place too readily to the mere mass of school pupils. In her address to the graduating class of Goucher College, June 5 of this year, on which occasion she was the recipient of an honorary LL.D. degree, Frances Perkins, Secretary of Labor, said that among the lists for which mail order houses paid the highest prices were those of school teachers. It would seem, then, that merely in reaching 3100 school teachers annually the Medical Society enjoys at least an enviable opportunity.

On the 26th of April, 1933, your Field Secretary was introduced to the pupils of Princeton High School by Dr. William G. Schauffler. The local papers noted the fact that this was his last public appearance. Although he looked and, according to his own confession, felt "far from well", he demanded of himself practically this last ounce of his waning strength to endorse and support the affiliation of his own State Medical Society with the educational institutions of that State. More than once from this floor, he has stressed his belief in the soundness of this pioneer undertaking of these men of his profession with whom he was most closely associated. Although he might have been called "a gentleman of the old school", he was, nevertheless, "a modern" in his attitude toward all that was progressive and public spirited. As a scholar of recognized merit, a man of unblemished integrity, and a physician who embodied the ideal of the profession, no citizen of Princeton, no member of the Medical Society, held higher place in the affection and esteem of those with whom he came in contact. His very presence on the platform that morning at the Princeton High School assembly gave professional authority to the advice offered those students, combined with a kindly solicitude for their serious consideration of its import in relation to their lives. As long as memory endures, that simple, final act of an exhausted, loyal soul, will warm the chill hours of discouragement and doubt that are still to be met in the journey of at least one fellow traveler.

Respectfully submitted,
Ethel C. Taneyhill,
Field Secretary.

President Lippincott: What is your wish, in the matter of the Annual Report of the Field Secretary?

Dr. Olmstead: I move the report be accepted.

The motion was seconded, put to a vote and carried.

Secretary Morrison: Mr. Chairman, I have a resolution to present, which would, naturally, have come up at a later time, but it seems opportune to introduce it just now. (Reading, as follows.)

Resolution Regarding Food Faddists

Whereas much misinformation is being distributed today by food faddists relative to special diets, few, if any, of which can properly take the place of the older staple foods; and,

Whereas any properly balanced diet contains sufficient protein, fresh fruits and vegetables, especially leafy vegetables, and the better grades of bread which contain the proper vitamin, mineral salt and carbohydrate balances; and,

Whereas the claims of some of these faddists—that white bread, meat or any other article of staple food may be responsible for the development of grave diseases—are not supported by scientific data; therefore,

Be it resolved that the Medical Society of New Jersey wishes to inform the public that:

(1) The exaggerated claims set forth by food faddists are not supported by scientific data or even by practical experience, that we condemn the advertisement of such special diets in place of the older articles of food.

(2) The dangers of nutritional deficiencies in foods have been greatly exaggerated. No one food can be a perfect food. But a diet consisting of milk, cream, cheeses, leafy vegetables, fresh fruits, meats and easily digested starches and carbohydrates will furnish an excess of food values necessary for growth, development and the prevention of nutritional diseases.

(3) Any variation from a normal diet should be prescribed only by a family physician, and after a careful study of the nutritional and defensive values of a diet necessary for the patient seeking advice.

These resolutions have been largely drafted from those adopted by the Indiana State Medical Association.

I move its adoption.

The motion was seconded.

Dr. William N. Barbarito (Hudson County): I believe this motion is out of order at this time. It should come under new business.

President Lippincott: Dr. Morrison mentioned that, and explained why he thought this was an appropriate time.

Dr. Barbarito: I think it is a good motion, but I don't think it should apply at this particular time.

President Lippincott: Are you ready for the question?

The motion was put to a vote and carried.

President Lippincott: Report of the Board of Trustees will be put over until this evening. So, I now call for the Report of the Welfare Committee.

Dr. Schlichter read the report of the Welfare Committee.

Report of the Welfare Committee

The newly appointed Committee met at the Stacy-Trent Hotel on December 18, 1932, at the call of President Lippincott, and proceeded to organize: Dr. Charles H. Schlichter being unanimously elected Chairman.

A report upon State Society affairs covering the period of time since the Annual Meeting in June and up to December 1932, was submitted by the Executive Secretary, Dr. Henry O. Reik, who also directed our attention to certain matters carried over from last year.

Among the interesting features of his report, and one indicating the value of constant watchfulness, Dr. Reik told of his chancing to see, while traveling in Switzerland, in a Paris Edition of the New York Herald, an account of Governor Moore's appointment of the "Princeton Commission to study our existing methods of conducting the State's business and to recommend, if possible, a better plan"; of his having noticed that other professional and business representatives were being consulted but that medical affairs were, apparently, to be handled without any form of conference with physicians; of his having learned upon returning home that no one else had noticed this Commission nor held any knowledge of its work; and of his having, with the aid of Dr. Schauffler, opened negotiations with the Commission's Chairman and secured an invitation for our State Society to send a Committee to confer with the Commission on medical matters.

President Lippincott promptly appointed a Special Committee to follow up what the Executive Secretary and Dr. Schauffler had started and what proved to be an important relationship between the State Society and the Princeton Commission was established. A series of Conferences were held, in which we were represented by the Special Committee, consisting of Drs. Lippincott, McBride and Green, assisted by Drs. Schauffler, Morrison and Reik, and on some occasions by Drs. Mahaffey (and members of his Staff in the State Department of Health), Levy, McGuire, and English, called in because of their special knowledge regarding certain specific public health matters.

It was soon ascertained that matters affecting the medical profession had been given some attention but without much thought concerning the profession's interests. At conferences of our Committee with the Princeton Commission, the whole field of public health work was reviewed and many Committee suggestions were adopted by the Commission. Some of our recommendations have strengthened our position with regard to medical public relations; and we have supported all but 1 of the Commission's recommendations.

The important program of Post-War Legislation is being looked after by a Sub-Committee under the Chairmanship of Dr. McBride, which is study-

ing the medical care and hospitalization of Veterans of the World War. The recent action of Congress, however, giving President Roosevelt unlimited power in this matter, will probably change the picture.

The Majority and Minority Reports of the National Committee on the Costs of Medical Care are in the hands of a Special Sub-Committee for consideration, and a Majority and a Minority Report from this Special Sub-Committee, attached to this report, speak for themselves.

The Legislature of New Jersey is still in session as this report is being written, and it is impossible to predict, with any degree of safety, what will happen to some of the Bills in which we are interested, before adjournment is taken.

The uniform Narcotic Bill, designed to meet the requests of the United States Government and the American Medical Association S-229, has passed both Houses. It is now ready for signature by the Governor but is held up because the Attorney General has ruled that it is not legal for the State Health Department to be charged with the enforcement of a Narcotic Act. The Legislature removed the appropriation necessary to enforcement.

The Osteopathic Bill (S-226), on which a hearing was held, is still in Committee and it is felt that it will remain there.

The usual Bills designed to open widely a passage-way for the holders of limited licenses to secure the full rights and privileges of the Medical Practice Act have been introduced but most of them have been killed.

It was deemed inadvisable to introduce this year an amendment to the Hospital Lien Law dealing with physicians separately in this matter, but a Bill was introduced by some one unknown to us. Nothing has been done by the Legislature on this Bill.

Assembly Bill 170, dealing with the definition of Chiropody introduced by the Committee, has as yet not been acted upon by the Legislature. A *Public hearing* was held on S-125 and 126, at which we were represented by Counsel, and the Officers of the State Society and a number of members of the Welfare Committee attended. Those Bills were opposed because they would take away the "allocated funds" of the State Board of Medical Examiners; the only funds available for enforcing the Medical Practice Act. These Bills were considered dead but a Committee substitute for Senate 125, containing practically the same provision, has been introduced in the Senate and it contains the same objectionable features regarding the Legislature's control over the expenditure of dedicated funds as did the other Bills. It has been suggested that an amendment to this Bill, stating that "nothing in this act contained shall be construed to apply to the so-called Professional Examining and Licensing Boards", be introduced, and such an amendment has been sent to Dr. Andrew F. McBride, Chairman of Conference of Professional Societies, who is to call a meeting of the Conference of Professional Societies and send out a letter protesting against the Bill. Each member of the Welfare Committee has also been requested to use personal influence on his representatives. It is impossible at this late moment to have another meeting of the Welfare Committee prior to that of the State Society.

The so-called "Barbital Bill" has passed the House of Assembly and is now before the Senate.

The Executive Secretary and a Special Sub-Committee consisting of Drs. D. Leo Haggerty, Chairman; Harry R. North and George N. J. Sommer with Dr. James McGuire, Secretary of the State Board of Medical Examiners, was appointed to watch legislation. This they have been doing and will continue to do. These men and the Executive Secretary, Dr. Henry O. Reik, have analyzed and studied all Bills carefully, and have done splendid work in keeping the Welfare Committee advised as to the progress of legislation of even remote interest to the State Society. The plan that members of the Welfare Committee should individually maintain contact with legislative representatives—each, as to his own County Assemblymen and Senators—has been again followed this year and seems to continue working effectively.

Contact has been made by each member of this State Society Committee, either personally or through the various County Welfare Committees or County Public Health Relations Committees, with each State Senator and State Assemblyman. In this way we have been able to keep up and in constant touch with pending legislation, and to place our views before the legislators.

Dr. J. Lynn Mahaffey, State Director of Public Health, and Dr. James McGuire, Secretary of the State Board of Medical Examiners, have been present with this Committee at every meeting. Dr. Fischelis, Secretary of the State Board of Pharmacy, has been present at a number of meetings and his advice and suggestions regarding legislation have often been very helpful to the Committee.

Dr. Reik informs us further that, owing to the peculiar status of world affairs he has had to devote much more time than usual to national legislation, he, alone, serving for the State Society in its coöperation with the A. M. A. representative, Dr. Woodward.

The State Emergency Relief Administration, through its Manager, Col. Joseph H. Bigley, made a proposition for the payment of physicians' bills for attendance upon the registered indigents cared for by the Relief Administration. The Trustees appointed a Special Committee consisting of Drs. Frederic J. Quigley, J. Bennett Morrison and James S. Green to look into this matter. After this Committee met with Col. Bigley, a general committee was formed with 3 gentlemen named and the Chairman of the Board of Trustees, Dr. Andrew F. McBride; the Chairman of the Welfare Committee, Dr. Charles H. Schlichter; and the 5 Councilors, Drs. Christopher C. Beling, S. T. Snedecor, F. G. Scammell, James Fisher and Aldrich C. Crowe. This State-Wide Committee will undoubtedly report to the House of Delegates.

The attendance record of members of this Welfare Committee has been exceptionally good. Even in the most inclement weather, men have come long distances to be present and perform their duties, and there were but very few absentees from any of this Winter's sessions of the Welfare Committee. Too much in praise could not be said of the self-sacrificing work that these loyal members of the State Society are doing.

The services of the Executive Secretary have been of the greatest value to the Committee. Aside from the things previously mentioned, he has kept the Committee informed regarding all Bills, and his insight and forethought in legislative matters, and his experience in handling such a variety of problems have been of real value. He has established personal relations with many members of the Legislature, and when it was deemed necessary advised with them personally concerning urgent matters. The Chairman of your Welfare Committee is under a great personal obligation to Dr.

Reik for his splendid, willing and hearty coöperation in all matters pertaining to the work of the Committee.

I cannot close this report without reference to the death of our beloved associate, Dr. William G. Schauffler. On the Welfare Committee, as in all other activities of the State Society, Dr. Schauffler's word and counsel were frequently sought, always cheerfully given, and always in a spirit of understanding and justice. The Committee feels his loss keenly. It will be hard to replace him.

The Sub-Committee appointed to study the now famous Report on the Costs of Medical Care, like its prototype has submitted *majority* and *minority* reports, and with your permission, Mr. President, I will read them in their proper order and present them for such disposition as this House may see fit to make.

Charles H. Schlichter, M.D.,
Chairman.

Dr. Schlichter: Now, I have also for presentation, the *Majority* and the *Minority* Reports of the Sub-Committee, of the Welfare Committee, which was appointed to investigate the National Committee's Report on the Costs of Medical Care. I will read the *Majority Report* first, which was sent to me by Dr. Sherman, and then the *Minority Report*, submitted by Dr. Rubinow.

The Majority Report

This Sub-Committee was appointed to "study and advise the Welfare Committee of the action, if any should be taken, with regard to the recently published Report of the Committee on the Costs of Medical Care."

In simple terms, the problem which the Committee on the Costs of Medical Care set out to solve was that of furnishing good medical care at prices which the public can afford to pay. That the problem was not a simple one is attested by the fact that this committee of 50 experts and specialists in various lines, with its large staff of investigators, spent 5 years and a million dollars in fact-finding and other studies as a basis for its recommendations. The Committee has ended its labor and laid its foundling on the doorstep of the medical profession. Some critics have asserted that the "time and money were wasted". We are not in accord with this view. One important benefit which will surely accrue to the medical profession from this *Report* is a greater realization of our community of interests and the importance of organization. Proposals based on the *Recommendations* of the *Report* will no doubt be made, which can be dealt with successfully only by unity in thought and action. This matter is of vital importance to every practicing physician. Only after a thorough study of the *Report*, and of the various forms of *health insurance* and *state-medicine* which have been tried in this and other countries, can we be in a position to intelligently criticize or effectually oppose recommendations of the Committee or proposals from other sources that are unacceptable, or offer better alternatives.

Members of this Society are fortunate in having been provided with an easy means of familiarizing themselves with the contents of the *Report*. In the January issue of our Journal there is a masterpiece of summarization by the Editor, which gives in condensed form all of the essential features of the Wilbur Report. Therefore, for the sake of brevity in writing *this* report, we are assuming that all of you have availed yourselves of this opportunity. Also, in that same issue of the Journal, there is a great deal of other very important collateral reading. During the past 2-3 years our Journal has carried so many timely contributions on health insurance and allied subjects that it has become a very valuable reference source.

Recently the term *state medicine* has been the bug-a-boo of our profession. What is this terrible spectre, concerning the nature of which so many of us seem to have only a vague conception? The House of Delegates of the American Medical Association defined it, in 1922, as—"any form of medical treatment, provided, conducted, controlled or subsidized by the Federal or any State government, or municipality, except such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local County Medical Society, and are not disapproved by the State Medical Society of which it is a component part". For many years we have had state medicine in the medical care of the insane, of epileptics, of those having contagious diseases, of the indigent; and, also in preventive medicine, as regards public health activities, and the medical inspection of school children. All of these, and some others, are recognized and legitimate functions of the State or municipality when kept within reasonable bounds.

It is not those things that most of us have in mind when thinking of socialized or *state medicine*, but, rather, of *compulsory health insurance*. With the exception of workmen's compensation insurance, we have had in this country little or no experience with compulsory health insurance. That we will soon have to face definite proposals along this line is certain. At the recent Annual Dinner of the Milbank Foundation, which was one of the financial sponsors of the Committee on Medical Costs, Mr. Albert G. Milbank urged a plan for State-wide and nation-wide compulsory health insurance. Other powerful forces are at work on similar plans.

The Final Report of the Commission on Medical Education (the so-called Lowell Commission), referring to the importance of informing ourselves on these matters, says: "It is highly important that the medical and allied professions be informed of the merits and advantages, as well as the defects, of insurance plans containing certain elements which ought to contribute to better medical services. Sound plans of social legislation in this field cannot be developed more rapidly than sound professional and public opinions. There must be *evolution* from the present forms of medical care. It is doubtful if any plan, artificially superimposed on our present scheme, would meet with success. It seems clear, however, that the economic, political and social factors which have forced the development of sickness insurance in most countries of the world are also operating in this country."

That feature of the *Report* which received the most adverse criticism, both lay and medical, and which has been rejected by the *Minority group*, is the *Majority group's* "most fundamental specific proposal"; in which it recommends that—*preventive and therapeutic medical service be*

furnished largely by organized groups of physicians, dentists, nurses, pharmacists and other associated personnel, preferably around a hospital, for rendering complete home, hospital and office care, and that the costs be placed on a group-payment basis through the use of insurance, taxation or both. We believe that this proposal contains many objectionable and dangerous features, both for the people and for the medical profession, and that while there may be some exceptional communities to which it could be adapted, any wide-spread application of it is impracticable. The adoption of such a plan would almost certainly mean *state medicine,* for it is impossible to believe that it would not be necessary to use tax funds to help meet the costs, or that there would not be a dictating political bureaucracy to administer them. In criticism of this proposal the *Minority* report, among other things, says: "There is nothing in experience to show that it is a workable scheme, or that it would not contain evils of its own which would be worse than those it is supposed to alleviate. * * * * There is no evidence to prove that it would accomplish what ought to be the first object of the Committee—the lessening of the cost of medical care."

Most of the *Majority Report* signers were economists, sociologists, and physicians representing institutions and special interests. The latter might be termed *swivel-chair doctors;* for, while they are doubtless sincere, it is impossible for such individuals to get the view-point of the men in the front lines, i. e. of those in private practice of medicine, especially the general practitioners. They cannot understand that the mechanized, regimented, high-speed production methods of "big business" cannot be adapted to the intimate, personal relationships necessary in the practice of medicine. Apropos of this, the Report of the Commission on Medical Education says: "No scheme of organization or group responsibility can substitute for the priceless, discriminating, and sympathetic judgment of the competent and conscientious physician."

We, therefore, advise your disapproval of this fundamental proposal of the *Report,* and suggest your approval, in its stead, of the Minority Recommendations VI and VII, as follows:

VI

The *Minority* recommends that methods which can rightly be fitted into our present institutions and agencies be given careful trial without interfering with the fundamentals of medical practice.

VII

The *Minority* recommends the development, by State or County Medical Societies, of plans for medical care.

We especially commend the fifth *Minority Group Recommendation,* which says "that the corporate practice of medicine, financed through intermediate agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and sustained high quality of medical care, or unfair exploitation of the medical profession."

Of the other *Recommendations,* in both reports, there can be very little, if any, adverse criticism. On the contrary, most of them merit our hearty approval.

Article II of the *Minority* report, which—"recommends that government care of the indigent be expanded with the ultimate object of relieving the medical profession of this burden"—might well have contained a collateral recommendation relative to control of the abuse of medical charity.

It is apparent that the time is at hand, or very near, when certain changes in the present methods of distributing the costs of medical care will have to be considered. Statistical data in the *Report* show that the American people, at least under normal economic conditions, are able to meet the costs if they are spread over a period of time and among large groups. Some such plan is especially needed by individuals and families of the middle and low income classes, as a protection from the financial catastrophe of an unpredictable expensive illness. Probably no scheme can be devised which will be suitable for all communities. Furthermore, any plan to be successful must have the coöperation if not the leadership of the medical professions. We believe that the surest way to forestall socialized medicine and other objectionable proposals, is by informed preparedness on our part for this coöperation and leadership. Pertinent to this, we quote from Simons and Sanai: "* * * a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are entrusted to the medical professions."

We recommend the study of various plans which have been proposed or are now in operation in this country, such as: The Community Medical Service of Milwaukee County; the California Plan; the Suffolk County (N. Y.) Plan; the Vaughan Plan, of Detroit; and the Cleveland Public Health Council. We recommend that our State Medical Society, independently or following the lead of the A. M. A., adopt certain safeguards or principles which must be met by any plan or proposal seeking the coöperation of any member or members of this Society. The safeguards recommended by the *Minority Group,* and which we endorse, are:

(1) It must be under the control of the medical profession; but a "Grievance Board" to settle disputes, having lay representation, is permissible and desirable.

(2) It must guarantee not only nominal, but actual, free choice of physician.

(3) It must include all, or a large majority, of the members of the County Medical Society.

(4) The funds must be administered on a non-profit basis.

(5) It should provide for direct payment by the patient of a certain minimum amount, the common fund providing only that portion beyond the patient's means.

(6) It should make adequate provision for community care of the indigent.

(7) It must be entirely separate from any plan providing for cash benefits.

(8) It must not require certification of disability by the physician treating the patient.

A plan conforming to these specifications is that of the Milwaukee County Medical Society. It is one of the best that have been evolved and is adaptable to many communities in this State, if and when public and professional opinion is ready for a change.

It is doubtful whether there is as great a demand or desire by the American people for any radical innovations in our present system of medical care, as the hue and cry raised by certain well-meaning individuals would indicate. However, we will be fortified by a tolerant, sympathetic reception of all proposals and a willingness to cooperate in the use of those that are sound. On the other hand, we must not be stampeded into the acceptance of discredited communistic panaceas or hurriedly conceived plans. It would be far bet-

ter "to bear those ills we have than fly to others that we know not of".

We do know something of the ills of compulsory health insurance from the experience of European countries. We are opposed to it, not only because of the abuses and evils which would follow the political control of medicine, but because of its demoralizing effect on those it is intended to benefit. We have had a little experience in this country with the morass of malingering engendered by the Workmen's Compensation Laws. In England, in 1929, under the panel system, 410,903 persons were referred to special regional offices as chronic malingerers. Of these, 5/6 were found to be receiving benefits for feigned illness. A physician, who is a member of Parliament, said: "The people are being converted into loafers and hypochondriacs." Under the system in vogue in Germany conditions are much worse.

Happily, many outside of the medical profession share our views on socialized medicine. Commenting on this subject, The Ladies Home Journal recently said: "The medical profession has itself long stood in fear of the introduction of *state medicine*. The public has even greater reason to fear such a system."

Elbert S. Sherman, Chairman.
Joseph Londrigan
John H. Rowland
Joseph M. Kuder
L. H. Bloom

Minority Report

I have dissented from the report of the Sub-Committee on "Medical Costs" for the reason that this Sub-Committee has held no meetings, and its members given no opportunity to discuss the subject. The report recently submitted to you represents the individual opinion of the Chairman and was accepted by the other members without any modification after a single reading ½ hr. before it was presented to the Welfare Committee. As I do not share the attitude and views expressed in the report, and having been appointed by you to the membership of the Sub-Committee, I feel it is my duty as well as privilege to submit to you for consideration my personal opinion, based on the study of the following sources of information.

(1) The Report of the Wilbur Committee.

(2) The Report of the Lowell Committee.

(3) The investigations of Sir Arthur Newsholme (Medicine and the State).

(4) The Way of Health Insurance, by Simons and Sinai.

(5) The vast literature on the subject published in our own State Society Journal.

(6) The various reports, addresses and discussions in the Bulletin of the A. M. A.

(7) Editorials and articles in the medical and lay press.

In perusing the wealth of literature on the subject one should endeavor to separate the factual material, painstakingly gathered by highly expert Staffs of research workers, from attitudes, influenced by traditions, fears and leanings toward one or another trend of social philosophy. If one keeps this in mind he will find that the various investigating bodies are in full accord with respect to the summary of findings. There is no dissenting voice to the established few truths, namely: that the predominating portion of the American people are unable, even in times of prosperity, to meet the cost of medical care, because their family income is not enough to meet the minimum standard of decent living, because medical care cannot be budgeted for individually, because incidence of sickness is irregular, and that therefore the American people are not getting the necessary and available care. "Inability to pay for medical care", states the Wilbur Report, "results partly from inadequacy of income, and partly from the fact that for the individual family the costs of medical care are unevenly distributed over time, that they are unpredictable in size, and cannot be budgeted." The Lowell Report concurs in this opinion. It says, "Although the total income of the population of the United States is large, it is estimated that about 80% of workers have an annual income of $2000 or less. Many of the population receive an income so low, that they are handicapped in trying to provide individually for the emergency of illness, the uncertainty of employment, and the necessities of old age. The relatively low average income of workers, in relation to what is considered to be the minimum cost of maintaining a decent standard of living, is a feature of the highly uneven distribution of wealth and a vital consideration in making any plans for an adequate medical service for the entire population. The cost of adequate medical care might possibly have been carried by as much as 90% of the population if the costs had been distributed through some form of insurance."

"The annual income of 90% of the families in the United States and Canada", says Dr. Harvey Smith, in his Presidential Address before the British Medical Association, in Canada, in 1930, "is below $2000 a year, which makes it easy to understand why the problem of sickness so often assumes the proportions of a financial tragedy". *"The problem of medical care has ceased to be one which can be solved by direct family payment and the best method has to be determined for securing satisfactory medcial care by provident measures,* (insurance) supplemented by communal aid (taxes)." Herbert L. Lombard, Director Division of Adult Hygiene Mass. Dept. of Public Health, finds that 1/3 of all persons sick with chronic diseases are not receiving medical attention.

All the above quotations are dealing with the *quantity* of medical care but there is also a unanimous opinion, that the *quality* of medical care is to a great extent inadequate, due to the growth of scientific medicine, to the changes in methods and technic of diagnosis. "Even conceding adequate original education and training, in view of the rapidly increasing body of scientific knowledge it is difficult for a considerable percentage of practitioners under present circumstances to keep up to date." (Wilbur Report.)

This is the paramount issue facing the American people and the medical profession alike. "The delivery of adequate scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations of life, is the outstanding problem for the medical profession today" (Dr. Olin West). One may only add to this that the solution of this problem is beyond the resources of the medical profession standing alone. The combined efforts of the organized medical profession coöperating with other groups of society are necessary for any steps toward the set goal.

There are only 2 methods known, by which an economic burden affecting an individual or a group of individuals in an organized society can be relieved by spreading it to the society as a whole. These methods are: *taxation* and *insurance.* The principle of taxation is accepted by both the *Majority* and *Minority* groups of the Wilbur Commit-

tee only as a supplement to other plans: to provide for the indigent and those patients with diseases which can be cared for only in government institutions, to expand the public health services, and to subsidize the rural areas. But the main controversies are centered around the question of *health insurance.* Here again there is a general acceptance of the *principle of insurance.* Even the *Minority* report, which is opposed to any wide scheme of insurance, recommends "the adoption of insurance methods only when they can be kept under professional control". The Commission on Medical Education advocates the principle of insurance and states that "the current trends of sickness insurance are toward compulsory instead of voluntary insurance, and points out that the factors which forced the development of sickness insurance in most countries are also operating in this country". The *Majority* report of the Wilbur Committee is likewise strongly *advocating the principle of health insurance* but disagrees on the question of *voluntary* vs. *compulsory* methods. One might point out here that all the students of health insurance in this country and abroad are unanimous in their conclusions that voluntary health insurance schemes do not reach those groups which are mostly in need of it, that they have proved to be only a stage in the development of compulsory coverage. "Every so-called voluntary system", say Simon and Sinai, 'is successful in just about the proportion that it contains compulsory features". At present, 23 countries have adopted the principle of compulsion to distribute the economic hazards of illness among those elements of the population which have a narrow economic margin (Comm. Med. Ed.). "One must conclude", writes Sir Arthur Newsholme, "that in all European countries sickness insurance and its medical benefits are beneficial and that reform, not abolition, is needed."

Turning to the reactions of our society at large toward those vital problems, the Lowell Commission says: 'Various agencies have built up in this country a health consciousness which is creating a demand, that methods of science shall be made effective and available for all." As stated by Michael Davis: "The general principle of insurance has found increasing support in recent years. The present widespread discussion of unemployment insurance indicates it. It is inconceivable that unemployment insurance will not be extended to cover sickness." And, Simon and Sinai point out that in countries, where the medical professions have not prepared for and assumed a position of leadership in the new social and economic phases of health care, the profession's indifference tends to be reflected in corresponding indifference or even hostility to the medical profession on the part of the public.

The medical profession's interest in this problem is not to be overlooked. It will suffice to state that while a great many people are not receiving proper medical care, thousands and thousands of physicians, young and middle-aged, are not utilizing their time, their acquired training, nor their eagerness for work, and have to struggle for a decent living without any fault of their own.

Considering all the above facts and statements, one is rather at a loss to understand the negative stand toward any constructive health insurance plans on the large part of the organized medical profession. It may be explained by several causes; the unjustified stand taken by the Editor of the A. M. A.; the fear of the spectre of *state medicine* and the opposition to any new ideas on the part of many leaders of the profession, who fail to appraise the changing features in modern community life. "The outstanding characterization of civilization is change", says the Commission on Medical Education, and "a satisfactory plan for medical services is one of the most important factors in civilization, which hopes to provide security and protection for the lives of the people." Professor Hamilton, of Yale, following up the historic evolution of medicine, shows that in a pre-industrial era medicine, in the hands of private practitioners, was a *public service.* To preserve this status in a competitive industrial world is the paramount end and it can be obtained only by a complete elimination of profit-making from the practice of the art. "The ordinary physician", he says, "is an artist who esteems far more highly than the dubious chance of wealth a regular and an adequate income, the feeling of security, and freedom to devote himself in an uncomprising way to his calling." The prevailing fear of *state medicine,* shared by so many, is entirely unfounded. Sickness insurance is not state medicine, assert Simon and Sinai in their excellent book entitled—"The Way of Health Insurance"; since the physician and dentist are not government employees, nor is the system administered by government officials, nor does it obtain its main support from taxation. Health insurance and private medical practice can and do co-exist. The organized profession should use all its resources, all its strength, which may prove to be great if used in the proper time and in a proper way, to have full control of the medical arrangement in any scheme of health insurance. 'Therefore, organized medicine must formulate its own application of the health insurance principle, if it is to remain master of its own destiny." (Bulletin A. M. A.)

The other important recommendation of the Wilbur Committee, which met with an overwhelming opposition on the part of the medical profession, is *Recommendation No. 1,* which advocates "group practice organized preferably around medical centers" for rendering complete home, office and hospital care. This strikes at the very heart of present medical practice and objections to this plan pointed out by the *Minority* group are essential. (1) It would establish a medical hierarchy in every community. (2) It would be impossible to prevent competition among the many such centers necessary for large cities. (3) Continuous personal relationship of physician and patient would be difficult if not impossible under such conditions. To these valid objections one may add the following: Many of the existing medical centers have been organized in such a haphazard way, their policies have been often so anti-professional and anti-social that they gained neither the confidence of the community nor of the profession. Furthermore, one cannot see how this scheme could absorb all the practitioners of any large sized community. And there is no necessity for it in 70% to 85% of minor illnesses which the individual physician is perfectly able to take care of. To overcome the difficulties pointed out by the *Majority* and given as reasons for their suggested scheme, other simpler remedies are available. Those difficulties are: Lack of coördination between general practitioners and specialists; the isolation of some practitioners from helpful contacts with hospitals and medical agencies; the enforced idleness of many physicians and the increasing complexity of medical service which necessitates the use of ever multiplying equipment. These difficulties are of great importance but can be overcome by simpler ways without creating more new difficulties and without

destroying the valuable features of the present medical practice, as will be shown below.

Both the *Majority* and *Minority* reports, as well as the Committee on Medical Education, are in favor of improving the status of the family physician. But only in one footnote, signed by Dr. Walter R. Steiner, can be found a suggestion how to achieve this end. I quote this footnote as it appears to be of the greatest importance.

"In order carefully to safeguard and preserve the very essential, personal relationship between physician and patient, and to restore the private general practitioner to his rightful place as the key-man in any effective system of rendering medical service, to which his contribution to the profession and to the social order entitles him, we would urgently recommend that every person select a personal or family physician to whom shall be submitted all health problems as well as illness problems: we urge the coöperation of this personal or family physician with available laboratories and specialists, the free use of the services of all such whenever and wherever needed, and the close coördination of such service in rendering adequate and complete medical care. We consider this kind of coöperation better and fairer to all parties, than the organization of professional personnel into partnerships or groups around hospitals or clinics."

Here is the crux of the matter. In 70% to 85% of illnesses the family physician is competent to render adequate medical care. In the remaining 15% to 30% he should be provided with facilities of laboratories and consultants within the means of the patient or free when it is needed. To accomplish this end: (1) All the existing hospitals, municipal as well as so-called private, which are after all supported by public funds, shall be wide open to every practitioner in the community. (2) Every organized medical society should arrange for a non-profit making, diagnostic and consultative clinic, to serve its members when necessary. Fees in such laboratories should be charged according to the means of the patient, or be free when needed, and the income, incurred after all expenses are paid, apportioned to the medical personnel. Such a scheme would in reality elevate the standing of the family physician and render his services as satisfactorily as in a group clinic.

The *Recommendation* dealing with public health services will not be discussed here, as there seems to be no disagreement on this point, and besides, the public health committee is studying these problems and will present its own report.

What shall be the attitude of our State Medical Society toward all those vital issues? To evade the issues and recommend further study, would seem inopportune in view of the extensive research, conducted at large cost and during a 5-year period by such competent bodies as the Wilbur and Lowell Committees. One feels that the time is now ripe for definite action. The responsibility facing the New Jersey State Medical Society is to take a definite stand suitable to the conditions of our own State. New Jersey is essentially an industrial State. The 1930 census shows in New Jersey a population of 4,041,344, of which 3,339,249 is urban and 702,090 rural. The population is quite concentrated in the northern part, so that 5 counties: Essex, Hudson, Union, Passaic and Bergen, have an average of 5734 people per square mile, while the average for the State is 537 people per square mile. Of the 3,330,748 people more than 10 years old 1,712,125 are engaged in gainful occupations.

64,471—in agriculture.
736,285—in manufacturing and mechanical industries.
176,949—in transportation.
329,327—trades.
41,520—public service.
125,641—professional services.
170,492—domestic service.
57,492—industries not specified.

These figures tend to prove that New Jersey is better fitted than many another State for adoption, through legislation, of a broad system of required health insurance. It is commonly agreed that the medical profession will fare better if it takes, of itself, the initiative of promulgating the proper measures.

Dr. Milton Robb, of Detroit, in an excellent address before the Annual Conference of Secretaries and Editors of Constituent State Medical Associations, points it out very forcibly. Discussing various health insurance plans, he says: "If our profession does not take action immediately, the opportunities to control the administration of these plans may be lost to the physicians for all time. Should legislative bodies step in and make health insurance compulsory, who shall be in control, the medical profession or the profit-making lay insurance companies? This, is the vital question. Now, is the time to act." And Olin West concurs in this opinion: "If innovations are to be made in medical practice, I hope they will originate with the profession and be under its control."

One realizes that it is, of course, much easier to state a principle than to work out its details and to put them into force whether by persuasion or by statutes. But without an underlying principle, no definite measure can be successfully realized.

There is, too, another point. Behind the whole problem of medical care, is the general economic problem of the people. Obviously, the medical profession is not in a position to solve those problems by its singular efforts. While it is urgent that the medical profession shall take the initiative, it must seek the coöperation of other agencies: Foundations and social agencies, competent economists, representatives of employers and employees and government bodies. Only the concentrated efforts of all interested groups will spell success.

On the basis of the above facts and statements by authoritative bodies, one feels justified in making the following recommendations for consideration by the State Medical Society.

(1) The State Society shall reject *Recommendation No. 1* of the *Report* pertaining to group practice centered around medical centers.

(2) The State Society shall endeavor to devise means to improve the status of the family physician on the basis of suggestions outlined above.

(3) The State Society shall go on record as favoring the broad application of the principle of health insurance for the country at large and declare itself in favor of required health insurance for the State of New Jersey as best suited and most practicable to the economic conditions of the State.

(4) An influential active committee shall be appointed by the Medical State Society. This committee shall get in contact with all other agencies in the State, having an interest in health insurance, for the purpose of working out a detailed plan to cover the medical needs of the State..

Saul M. Rubinow, M.D.

President Lippincott: You have heard the report of the Welfare Committee. What is your pleasure?

Dr. Quigley: Mr. President, in moving that these Reports be received, I would like to comment upon them, briefly.

Dr. Sherman is to be congratulated on his excellent, well-considered report. While I don't agree, personally, with the idea of compulsory health insurance, I feel that his is the best exposition of this subject I have heard.

I move, in receiving these reports, that these gentlemen be thanked for the excellence of their reports.

The motion was seconded, put to a vote and carried.

President Lippincott: It has been suggested that this complete Report should be referred to the Business Committee. If there is no objection, that will be done.

Now, for the Report of the Judicial Council.

Dr. Christopher C. Beling read the Report of the Judicial Council.

Report of the Judicial Council

During the past year the Judicial Council was called upon to act with a special committee appointed by the Board of Trustees to assist the Emergency Relief Administration to formulate policies, in detail, for a State-wide plan for medical relief.

The Council has met on several occasions to consider other important matters presented to it by the various County Societies and by the State Society.

First District

The Component Societies of the First District have held regular meetings and maintained a high standard of scientific work. The activities of these Societies have been largely reported in the Journal of the Society.

A First District Councilor Meeting was held in January. At this meeting, which was well attended, the subjects "The Cost of Medical Care" and "Specialism" were ably presented and extensively discussed.

It has been planned for each County Society, in rotation, to take charge of such a District Conference and be responsible for the program.

Christopher C. Beling,
Councilor First District.

Second District

All of the societies in this district have had exceptionally active meetings during the past year. Each devoted one meeting to a consideration of the Report on the Cost of Medical Care. In general, an increased interest and activity have been noticeable throughout our District, as witnessed by visits to the individual societies.

A meeting of the Officers and Delegates of the district was held in Hackensack about the middle of May.

Spencer T. Snedecor,
Councilor Second District.

Third District

The Component Counties of the Third District are in a flourishing condition. Regular meetings have been held. The Scientific Work has been of the usual high standard. The activities of the members of the different County Societies have been more acute during the period of the depression. Following the suggestion of the State Society, a District Meeting was held at New Brunswick, in Middlesex County. It was ably presided over by the Middlesex County Society's President, Dr. Robert McKiernan. This meeting was held at Johnson and Johnson's and the firm acted as our host and demonstrated the necessity of using surgical supplies made in America.

Frank G. Scammell,
Councilor Third District.

Fourth District

On April 4, the Fourth District Meeting was held at the Camden Club, Camden, New Jersey; at which Meeting there were about 62 members present. A dinner was served, following which Dr. Seth Brumm, Chairman of the Committee on Economics of the Philadelphia County Medical Society, spoke on the subject—"What of the Doctor's Economic Future?" Considerable discussion followed and an abstract of this speech has since been published in the May issue of the Journal of the New Jersey State Medical Society. Following a 20-minute recess, the Camden County Medical Society presented a program of very great interest.

James A. Fisher,
Councilor Fourth District.

Fifth District

Every County in this district was visited during the past year. A very successful meeting was held at Salem in May. This meeting was well attended. The *ethical conduct* of all our members in the Fifth District has been excellent.

Aldrich C. Crowe,
Councilor Fifth District.

President Lippincott: You have heard the Report of the Judicial Council, and the motion to adopt. All in favor will signify by saying, "Aye". Contrary, "No". It is adopted.

A motion to adjourn is in order.

It was regularly moved, seconded and carried, that the meeting adjourn, which was done at 5.20 p. m.

Tuesday Evening Session

June 6, 1933

The second session of the House of Delegates of the Medical Society of New Jersey convened at 8.30 p. m., with Dr. John F. Hagerty presiding.

Chairman Hagerty: The President is detained at a meeting of the Board of Trustees and has asked me to open this session on time in order to expedite matters.

May I ask that Dr. Pinneo act as secretary pro tem in the absence of Dr. Morrison?

The Report of the Treasurer would be the next order of business, but Dr. Marsh is also attending a meeting of the Board of Trustees.

I will ask Dr. Barkhorn to present the Report of the Committee on Publication.

Dr. H. C. Barkhorn read the Report of the Committee on Publication.

Publication Committee Report

The Publication Committee reports a successful year. With the coöperation of the Editor we were $942.93 under the budget of $14,500 granted us by vote of the House of Delegates, and only $57.07 over the budget of $13,500 we voluntarily promised to attempt when the Committee on Finance and Budget found they could not balance the budget on a $10 per capita assessment. Our total expense for the year was $13,557.07; while net receipts were $6741.08; leaving a deficit of $6815.99.

If, in our bookkeeping, we had been credited with $1 for each member, as is done in New York State, our ratio of deficit would be exactly the same as in New York. As we accept only "Council approved" advertisements, and as receipts from the Coöperative Bureau of the A. M. A. were reduced more in proportion than those secured locally, the committee feels this a very good showing for times such as these.

During the year we published 963 pages of reading matter including the very splendid January Special Economics Number, copies of which were in great demand. We published 86 articles by our own members out of a total of 108 articles published during the year.

Our printing contract expires shortly. We are prepared to get new estimates and hope to save money for the Society by this factor. We can publish a Journal of any size desired per year, at a gross cost of about $1450 per hundred pages of reading matter.

We are unable to publish the Journal we should, and to publish all the satisfactory papers submitted by our own members, on a $13,500 budget. If we are to continue to have a yearly Journal of about 1000 pages, we recommend a return to the appropriation of $14,500 for next year.

The members of this committee feel, unanimously, that this matter should be carefully considered by the Board of Trustees so that they may recommend to the House of Delegates what size the Journal should be, not leaving the issue in the hands of the Publication Committee, the Editor, or the Budget and Finance Committee.

Henry C. Barkhorn, Chairman
Edward J. Ill
Linn Emerson

RECEIPTS

Advertising	$ 9235.89
Coöperative Medical Adv. Bureau Rebate	335.10
Extra subscriptions	54.60
Sale of Journal	20.43
Bills Receivable	998.40
	$10,644.42

EXPENDITURES

Commissions paid Coöperative	$ 779.64
Commissions paid local agents	426.00
Discounts	184.51
Chairman's salary	375.00
Chairman's expenses	90.00
Tax on checks	.30
Uncollectable accounts	231.62
Printing and mailing of Journal	12,675.79
Reprints	231.50
Index	145.00
Addressograph	34.58
Dr. Reddan's half-tone	5.20
	$15,179.14

COMPARATIVE STATEMENT

	1931-32	1932-33
Advertising	$10,924.83	$ 9,235.89
Extra subscriptions	59.10	54.60
Sale of Journal	13.48	20.43
Printing and Mailing of Journal	13,472.34	12,675.79
Reprints	241.00	231.50
Commissions	1,427.97	1,205.64
Discounts	245.36	184.51

SUMMARY

Amount of advertising secured by Coöperative	$3706.61
Amount of advertising secured locally	4139.13
Discount and commission allowed Coöperative	935.60
Discount allowed local advertisers	28.55
Commission paid local agents	426.00
Total amount of advertising	7845.74
Total cash receipts, all sources	7167.38
Total amount paid Treasurer	6741.08

RECEIPTS AND NET EXPENSES FOR THE YEAR

Total receipts	$7167.38
Bills receivable	998.40
	$8165.78

EXPENSES

Printing and mailing of Journal	$12,675.79
Reprints	231.50
Index	145.00
Addressograph	34.58
Dr. Reddan's half-tone	5.20
Chairman's salary	375.00
Chairman's expenses	90.00
	$13,557.07

Chairman Hagerty: You have heard the report of the Committee on Publication, what is your pleasure?

It was regularly moved, seconded and carried, that the report be accepted as read.

Chairman Hagerty: We shall now have the Report of the Committee on Honorary Membership. (No response.)

We will have the Report of the Committee on Hospitals and Medical Education. (No response.)

Report of the Committee on Indemnity Insurance, Dr. Beling.

Dr. Beling read the report of the Committee on Indemnity Insurance.

Twelfth Annual Report of the Committee on Medical Defense and Insurance, 1933

Since 1921, the Medical Society of New Jersey, by its agreement with the United States Fidelity and Guaranty Company of Baltimore, has been affording its members the opportunity to obtain insurance against malpractice claims at special rates, made available only to members in good standing. As a result of this requirement, the Society, as well as the individual member, has been benefited.

This year, there has been a further gain in the number of members insured. Last year the number was 1886; this year it is 1924, not including approximately 100 members whose names will be automatically added to the list when arrears in dues have been paid. The following table sets forth the percentage of members insured by Counties:

County	Membership	Insured	Percentage
Atlantic	103	70	.679
Bergen	191	143	.748
Burlington	52	29	.557
Camden	139	86	.611
Cape May	21	13	.619
Cumberland	49	32	.653
Essex	726	564	.776
Gloucester	34	19	.558
Hudson	420	281	.669
Hunterdon	25	12	.48
Mercer	160	133	.831
Middlesex	122	73	.599
Monmouth	80	48	.60
Morris	86	59	.686
Ocean	21	9	.428
Passaic	202	124	.613
Salem	16	10	.625
Somerset	46	24	.521
Sussex	18	7	.388
Union	219	176	.803
Warren	23	12	.521
	2753	1924	.699

The Company's records show that during the past year, of the 70 claims reported, a considerable number occurred as far back as 1929, 1930 and 1931; that 28 claims are pending in suit; 19 are still open; and the balance closed.

The causes alleged in the claims made last year, are as follows: Surgical causes, 12; mistake in prescription, 1; mistake in diagnosis, 4; fractures, 3; lamp burn, 1; neglect or unskillful treatment, 4; negligence in preventing suicide, 1; hot-water bottle burn, 1; conspiracy, 1; broken hypodermic needle, 1; commitment to institution, 3; one case involved 4 doctors; broken needle in chest, 2; electric baker burn, 1; careless exposure to contagion, 1; death under chloroform anesthesia, 1; injury from falling x-ray stand, 1; infection following injection, 2; Cesarean operation neglect, 1; nose and throat neglect, 2; wrong x-ray diagnosis, 1; gangrene (torniquet), 1; obstetric neglect, 2; neosalvarsan reaction, 1.

There were no x-ray burns or radium claims. In this class of risk high standard requirements and thorough investigation of the competency of applicants by a special committee before their acceptance by the Company has been an important factor in producing a favorable experience and preventing an increase of premium rates. If this improved experience is continued for another year, the committee will ask the Company for premium reductions.

In the general class the Company has continued to sustain losses and as the result of its unfavorable experience, it has been forced to promulgate a revised schedule of rates as follows:

Limits	Present Rates	New Rates
$10/$30,000	$16.00	$20.00
25/ 75,000	23.50	31.00
50/150,000	35.00	39.20

There will be no change in rates to physicians giving x-ray and radium treatments.

The committee made an investigation of the rates charged in other States and have compared them with the new rates. The new rates are still lower than the rates in the other States.

New York	Massachusetts	Pennsylvania
$5/$15,000 $34.00	$20 to $70 for	$5/$15,000—$25.00
10/ 30,000 43.84	ordinary prac-	10/ 30,000— 30.50
25/ 75,000 65.12	titioner. (See	25/ 75,000— 39.50
50/100,000 74.88	note.)	50/150,000— 56.25

Note: Massachusetts has a similar plan on a Society basis as New Jersey, the rates as shown above applicable with exception that physicians are classified. Extra charges for assistants, technicians, nurses, x-ray diagnosis, etc.

Up to the present time the premium rates have been exceptionally low, in fact lower than in any other State. Last year the claim experience of the Company justified an increase in rates, but in view of an understanding with the Company, the rates were not increased. It was thought that the numbers of claims might be reduced by closer coöperation of the members in avoiding malpractice actions. Despite all efforts to keep down the cost of investigation, litigation and settlements of claims, the experience has shown that there has been a loss to the Company at the present schedule of rates.

We have been advised by the Company that on the claims reported since the last Annual Meeting the settlements and reserves set up amount to $34,500, not taking into consideration attorneys' fees, which have accumulated on cases in suit, and expenses for investigation of cases in suit or in process of settlement.

The Committee recommends that the new schedule of rates be accepted and the contract renewed for the ensuing year through the same broker, Mr. William N. Heard.

We desire at this time to express our great appreciation to Mr. Heard for all the work he has done with unfailing energy to increase the number of members taking advantage of the insurance plan of the Society. In his personal contacts with the physicians, he has been able to clarify many misconceptions regarding the contract, the kind of service rendered and the efforts being made by the Society in behalf of its members.

The Committee desires to call the attention of members who are insured under the special policy of the State Society to the absolute necessity of employing every safeguard to prevent the institution of suits. The idea is prevalent in the minds of some that as long as they are insured there is nothing more for them to worry about; that the Insurance Company will defend them and pay any damages that are assessed against them. For this reason, they are only too willing to have the Company settle claims without justification or contest. This idea will soon breed negligence on the part of

the insured and also encourage patients to bring suits with the hope of obtaining settlements. No doubt, certain lawyers will readily aid them. Each individual member must remember that he has a duty to all the other members of the group, to keep down expenses so that the amount collected on the premiums is not exceeded in the maintenance of defense and damages. As it has now happened, the Company has lost money on the business and has to ask for more money to give us the service we expect of it. It is, therefore, up to us to do all in our power to keep down the expenses. How can we do this? We should be thorough in the care of our patients, keep accurate records, and be sure of our diagnosis, and when in doubt, have consultations with other physicians. When the Society was defending its members under the old Medical Defense Act, very few suits against the doctors were successfully maintained, and few, if any, suits were settled. Every case was closely scrutinized by the Judicial Council and many never reached the Courts. To gain some of the loss we have thereby sustained this last year the coöperation of the Councilor of the District in which the case happened to be was obtained. In many instances the aid given by the Councilor has been very valuable. It is hoped that during the coming year a closer coöperation may be brought about with the Judicial Council.

We wish to impress the fact that medical defense is not the concern of the Committee, of the Councilors or the Officers of the Society, but it is and must be the concern of every individual member, and he should be just as sensitive to the welfare of his fellow practitioner as to his own. If we do not unite to protect ourselves and maintain the right against all sorts of fraudulent devices, we shall have to pay larger and larger premiums as one of the consequences of our failure.

In conclusion, to make a real success of medical protection, we must have the wholehearted support of every member. There are over 700 members who are not insured under our contract. We would like to have them join with us and help us to perfect efficient organization at a minimum cost.

Respectfully submitted,

Christopher C. Beling, Chairman
Edgar A. Ill
John F. McCoy
Erwin Reissman
Frank G. Scammell

Committee

Chairman Hagerty: You have heard the report of the Committee on Indemnity Insurance. What is your pleasure?

Dr. E. Reissman: I move the report be accepted and the recommendations adopted.

The motion was seconded, put to a vote and carried.

Chairman Hagerty: The next order of business is the Report of the Committee on Group Health and Accident Insurance, Dr. Pinneo, Chairman.

Dr. Frank W. Pinneo: Preliminary to presenting this report, let me remind you of what Dr. Beling said about these being the interests of all and if all the members will coöperate, it will be to the benefit of all and help in premiums, and help in reduced costs. That applies to all our insurance.

Seventh Annual Report of Committee on Life, Accident and Health, and Automobile Insurance

Accident and Health Insurance

This report is for the year ending April 15, 1933. We have already reported successful negotiations for (1) longer period of indemnity for sickness not house-confining, now 6 weeks instead of 4, and (2) liberal interpretation of total disability which now need not be strictly "house-confining". Indemnity for total disability, house-confining, remains unchanged, 52 weeks. Another advantage now offered is coverage for travel by aviation when by regular established air lines and piloted by licensed aviators, all this without any increase of premium.

The Members now carrying our Accident and Health policy number 224:

Atlantic County	6
Bergen	10
Burlington	5
Camden	11
Cape May	3
Cumberland	4
Essex	75
Gloucester	4
Hudson	27
Hunterdon	4
Mercer	13
Middlesex	8
Monmouth	2
Morris	8
Ocean	1
Passaic	9
Salem	2
Somerset	7
Sussex	1
Union	22
Warren	2
	224

Distributed as follows:

Ages—under 50	115
50 to 60	67
over 60	42
	224

Members receiving benefits during the year:

Ages—under 50	14	$2514.29
50 to 60	7	1804.93
over 60	6	1596.43
Total	27	$5915.65

These claims ranged from 1 day, $7.14, to 27 weeks, $1300.

Cases of uncompleted disability, 8.

Total premiums paid, $13,657.50.

Loss Ratio, approximately 43%.

The committee maintains arrangement with the insurance company whereby we are advised of all settlements of claims or other correspondence with our policy-holders. The agreement in our contract is that the Society, by its committee, must be a party to settlement in any case of disagreement between policy-holder and company. But, as uniformly hitherto, the dealings of the company with the policy-holders have been such that no difficulties have arisen. Only one case has called for our intervention.

A critical experience confronted us, when unexpectedly, we suddenly learned on April 19, that the International Re-Insurance Corporation, which absorbed the Independence Indemnity Company, underwriter of our policy, went into receivership. We immediately took action to find a strong company which would continue to write our policy, unchanged in any particular. Other companies were very willing to offer their own standard policies, but, refusing all such, we were determined to hold to the several exceptional advantages of our own; such as, broad coverage for common ills; low premiums for all ages in 3 groups; eligibility of any member, at any age, in good standing in the Medical Society of New Jersey. We achieved complete success in negotiations with the National Casualty Company of Detroit, which, furthermore, satisfied our investigations of security, financial reliability and a good record, this by judgment of the New Jersey, also, the Michigan, Commissioner of Banking and Insurance, and special reports from the Alfred M. Best Company of New York, a neutral company which functions for insurance like Dunn and Bradstreet for business.

Another objective was to save, if it were at all possible, the unearned premiums of our policyholders, although the company had failed, like other financial institutions, even the largest and safest, throughout the country. Even this we achieved by special negotiation, and on April 28, only 9 days after the receivership, we were able to notify our members that they were covered at noon exactly as before, and this without having to pay a dollar for loss through unearned premiums. This saved to about 200 members a total of about $6500. This notice was by a letter to every member holding a policy and signed, besides the committee, by the Officers, Drs. Lippincott, Quigley, McBride, Morrison and Marsh, whose confidence and coöperation the committee cordially appreciates.

Credit for these results must be given to the agents, E. & W. Blanksteen, 76 Montgomery Street, Jersey City, for their knowledge of insurance and zealous coöperation with us for the benefit of our members.

After these years of experience in Accident and Health Insurance, we recommend more assuredly than ever this particular policy, the result of our own negotiations and different from any others in the market; in low premium rates, breadth of coverage applicable to doctors' chances of accident and illness, and the eligibility of all members, at any age, in good standing. We believe a unique advantage is in the intimate contact of the committee both with claimants in their behalf on one hand and the underwriter on the other.

Automobile Insurance

Automobile insurance for members of the State Society was first suggested by Dr. Green, when President of the Society, and assigned to this committee for investigation. The policies for liability, property damage, fire and theft, etc., are standard policies at "conference", that is regular rates less a discount of from 15-30%.

Number of Members insured for Liability and Property Damage 363
Number of Members insured for Fire and Theft 170

	Liability & Property Damage	Fire & Theft
Essex	281	105
Bergen	21	12
Hudson	12	6
Morris	13	6
Union	15	11
Middlesex	4	4
Camden	3	1
Passaic	6	10
Monmouth	1	1
Sussex	1	3
Warren	1	0
Somerset	2	5
Atlantic	1	1
Mercer	2	5
	363	170

Total premiums paid for one year $18,000.00

Losses paid for Liability & Property Damage ..... $ 1,976.02
Losses paid for Fire & Theft 97.75

$ 2,073.77

Divided as follows:

Bergen County	$ 28.42
Union County	160.00
Passaic County	425.70
Essex County	1459.65
	$2073.77

Loss Ratio approximately 15%.

The agents are the Way-Conklin-Wolff Agency, 605 Broad Street, Newark.

The increase in number of policy-holders, both for Accident & Health and Automobile insurance is satisfactory evidence that the members want what is offered and that they have confidence in the service rendered by your committee. This has been cheerfully given and entirely without expense to the Society, except for some letter-heads and envelopes, supplied as to other committees.

In conclusion, we are gratified to offer to every member of the State Society in good standing, regardless of age, Accident & Health insurance, which all should carry, in a company which all reports commend for security; and automobile policies for those who may care to save a little money in premiums.

Respectfully submitted,

Frank W. Pinneo, Chairman
J. Finley Bell
Austin H. Coleman
James S. Green
Frederic J. Quigley
Chester I. Ulmer
Clarence W. Way

Dr. Pinneo: If anyone is inclined to ask why the new Company could be found that would underwrite such a loss, it can only be explained by the fact that such a Society, with such a potential business, made it reasonable in their forecast of what could be done and, therefore, the coöperation of the members in taking the insurance is a means of benefiting everyone.

Chairman Hagerty: What is your pleasure

with regard to the Report on Group Health and Accident Insurance?

Dr. Alfred Stahl: I move it be accepted and placed on file.

The motion was seconded, put to a vote and carried.

Chairman Hagerty: I have been asked to insert here the Report of the Committee on Public Health, Dr. Stanley Nichols, Chairman.

Dr. Stanley Nichols read the Report of the Committee on Public Health.

Report of the Public Health Committee

It is with deep sorow that this Committee opens its report by expressing its grief at the great loss, to both the Committee and the State Society, of its splendid Chairman, Dr. William G. Schauffler, who passed to his eternal reward on the very evening of the last Spring Meeting of the Committee. The Committee feels that if there is any place of honor that this State Society has set apart for high-minded physicians, who have put the affairs of their State and County Medical Societies, and all other forms of community health leadership, before their private interests, that our beloved Chairman of this Committee should be placed high on such an Honor Roll.

Your Committee has been busy this Winter making specific plans for the assumption of public health leadership by the organized medical profession of this State, by 2 methods:

(1) By having the Medical Society of New Jersey, through its Component County Societies, undertake 2 definite pieces of child health work.

(2) By having the State and County Societies link to themselves the various health services and agencies, by requesting their aid in the accomplishment of these definite pieces of health work.

It will interest the Society to know that as a preliminary to these plans, this Committee tested out the reaction of the State Health and Welfare Agencies, by offering to assist in preparation of health programs throughout the State. There was a very happy response to this offer from most of the agencies addressed, as well as many favorable comments on the coöperative attitude assumed by present-day physicians. Following this, the Committee invited all agencies having an interest in public health matters to work with our Committee, by sending representatives to conferences to be held from time to time, to consider the important questions affecting the public health in New Jersey; the *objectives* of these conferences to be *to crystallize and coördinate the interest of all of these health agencies* with the Medical Society of New Jersey, whose chief object it is to preserve and further the public health of this State.

Most of these agencies have already responded, stating that they are most heartily in favor of working with the State and County Medical Societies in public health matters by any and all means within their power.

Having ascertained this pleasing and coöperative attitude on the part of the public health agencies of New Jersey, your Committee calls attention to the stated purpose for which it was formed, namely:

(1) "To coöperate with the Public Health Section of the Continuation Committee of the New Jersey Conference on Child Health and Protection in studying public health matters in the State of New Jersey; and to coöperate with other Organizations and Departments dealing with Public Health."

Last June the Committee presented the following resolutions which were adopted by the Medical Society of New Jersey concerning: (1) State Board of Health; (2) the relation of physicians to child health activities; (3) relation of physicians to school health matters; (4) relation of physicians to hospitals and hospital clinics; (5) relation and coördination of physicians with health and welfare organizations.

* * * * * * *

(1) *Resolved* that the State Medical Society urgently recommends the continuance, by the Department of Health, of District Health Officers to the full limit allowed, namely 6. (At present only 5 such officers are provided for and by action of the Appropriation Committee of the Legislature these will probably be dropped.)

(2) *Resolved* that: (a) Physicians should be in attendance at every type of diagnostic or consultation station, whether it be for adults or children. (b) Physicians should be paid for such work. (c) Communities should be educated to an understanding that these services are not to replace the private physician but are for those only who cannot afford to pay a doctor. (d) This program should be carried out through friendly coöperation with organizations and public health authorities by the Public Health Committees of the State and County Medical Societies.

(3) *Resolved* that: (a) All *School Clinics* should be discouraged. Immunization against diphtheria, vaccinations, surgical, dental and eye clinics, and others, should all be discouraged, because of the danger of abuse of such clinics, and for the more important reason that such clinics should be relegated to their proper place—the hospital. In the rural districts, where there are no clinical facilities, the County Societies should make provision for indigent pupils as may seem most expedient. (b) All pre-school examinations and treatment should be done by the family physician. Immunization against diphtheria, and vaccination, should be done for all children during the first year of life, since it has been shown that 3/5 of all diphtheria cases in children occur before they are 5 years old.

(4) In view of the special problem created by the increasing number of persons availing themselves of free dispensary and hospital service who can afford to pay for medical service, and following the recommendation of the American College of Surgeons, that a definite system of determining the social status of the patient in relation to eligibility should be established, it is—

Resolved: that the State Society emphasize the necessity of developing a Social Service Department in connection with every hospital in the State, and, furthermore, that this phase of the work be delegated to the Woman's Auxiliary to the State Society.

(5) Regarding the Relation and Coördination of Physicians to Health and Welfare Organizations, the following *Principles* are suggested:

Principle 1. In order to establish a working relationship and coördination between physicians and health and welfare organizations, there must be created State and County Committees, or Councils, composed of the executive officials of the health or welfare organizations, with regular meetings to accomplish such coördination.

Principle 2. All public health or welfare work of a medical nature performed by physicians,

members of the State Medical Society, shall be on a salary basis, except during a limited initial period for demonstration value of such work.

Principle 3. Public or private organizations, and physicians doing health work of any character, shall administer such work so that all persons will be assisted in obtaining health facilities in direct proportion to their financial ability to carry their own responsibilities in this respect. A classification shall be made.

Suggested classification:

Class 1. Those persons financially able to carry their own responsibilities in regard to health matters.

Class 2. The under-privileged class, receiving less than the living wage and entirely unable to pay for health facilities. This class shall receive free treatment at public expense.

Class 3. Those persons who are only partly able to meet their health needs financially during severe or long continued illnesses or operations. The health needs of this class shall be adjusted by a cooperative plan conceived and directed by the State and County Medical Societies with the assistance of public and private health and welfare agencies.

Principle 4. All administration of these principles shall be with the object of preserving the private relationship between physician and patient.

Principle 5. It is now essential that State and County Medical Societies assume responsibility for the general health of the citizens of the State of New Jersey and provide means in coöperation with health and welfare agencies for the securing of health facilities by all persons regardless of their financial status. If this responsibility is not immediately assumed by the State Medical Society, political, health and welfare agencies, will assume, indeed have already partly assumed, this responsibility, which inevitably will lead to a disruption of the personal and private relationship between physician and patient which is the most desirable one for the health needs of the patient.

In view of the above enumerated principles, your Committee recommends the following resolutions:

(1) That State and County Committees, or Councils, be formed, composed of the executive officials of the State and County Medical Societies, together with executive officials of the Health and Welfare Organizations, for the purpose of holding regular meetings and coördinating their work.

(2) That the time has come for the State and County Medical Societies to assume leadership and rseponsibility for the general health of the citizens of New Jersey, and thereby to preserve the personal and private relationship between physician and patient, which is most desirable for the health needs of the patient.

In presenting this report, your Committee realizes that it has only made a beginning in study of the questions involved, and respectfully suggests that this study be continued.

* * * * * * *

This year our Committee offers the following resolutions:

(1) *Resolved* that our State and County Societies put into effect the resolutions enacted last year, through definite action in each County Society, by its Public Health Committee, on public health matters covered by the resolutions.

(Our State Committee offers the service of its members in an advisory capacity to the County Societies as to definite plans whereby these resolutions can be carried into effect in the various Counties.)

(2) *Resolved* that, as a definite step in the application of the *Principles* adopted in June 1932 by the Medical Society of New Jersey, regarding leadership by the medical profession in health matters, the State and County Societies undertake the Diphtheria Immunization of babies and children between the ages of 6 months and 6 years, preferably before the age of 2 years.

(3) *Resolved* that the State and County Societies sponsor and undertake *health supervision of the pre-school child,* by the bi-annual examination of the child between 2 and 6 years of age, by the family physician, his findings to be recorded on the "New Jersey Pre-School Record Form". (Note: The physician shall be paid for this service. This record form has already been prepared by this Committee and, when adopted by our State Society, will become the *uniform pre-school record,* and will be used by all *health agencies* in New Jersey. Furthermore, the various health agencies will be utilized, to put this form in the hands of every mother with a 2-year-old child in the State; she will be requested to have her family physician examine the child twice a year, record his findings and recommendations, and supervise and improve the health of the child. The mother will then be asked to present this record to the School Health Authorities on the child's admission to school.)

In view of the recommendations that have been made by various National Commissions, and conditions during the past 12 months, it is absolutely vital that we physicians pass on *at once* from academic discussion to *prompt and concerted action* along this line, if we are to *preserve* for the *physician* his *traditional* place in *human society.*

(4) *Resolved* that the State Society assume responsible health leadership, by directing its component Societies to immediately appoint County Society Health Service Committees, or similar bodies, to be composed of its leading public health minded physicians, and representatives of all health agencies, now existing, in each County, for the *stated object* of "providing by *existing health agencies,* adequate medical care, for all people in each County, at *costs within their means*".

By such action we may help develop better medical care in the State of New Jersey, by evolution rather than by revolution, and without middle men or other *superimposed* health machinery.

At least one County Society has already acted along this line and for comment and discussion the Monmouth County Plan is briefly outlined.

The Monmouth County Plan for Adequate Medical Care

Object of plan. To provide, by existing health agencies, adequate medical care, for all people in Monmouth County, at costs within their means.

By whom the plan is to be carried out: By a *committee* already formed in May 1933, to be known as the Monmouth County Medical Society Health Service Committee.

Composition of the Committee

(1) *Medical Service.* Public Health and Executive Committee members (12) of the Monmouth County Medical Society.

(2) *Dental Society.* The President of the Monmouth County Dental Society.

(3) *Hospital Services.* The Superintendents of the 2 standard hospitals; also the leading Executive Committee member of the Board of Governors of the 2 standard hospitals in Monmouth County.

(4) *Nursing Service.* The President of the Mon-

mouth County Section of the New Jersey State Nurses' Association.

(5) *Public Health Service.* The leading full-time Health Officer in Monmouth County.

(6) *Pharmaceutic Service*: The President of the Monmouth County Pharmaceutic Association.

(7) *Social Service*: The Health Director of the Monmouth County Organization for Social Service.

Advisory Members: Public Officials.

Meetings: To be held at least once in 6 months. At each meeting each health service to present its present day status, and its recommendations for coöperative *improvement* of its contribution to adequate and better medical care for all people in Monmouth County.

Sub-committees to be appointed for specific co-operative health plans. This Committee has already been formed and will hold its first county-wide conference *in September 1933,* which will be reported to the Journal.

Dr. Levy, by representing the State Committee on the program of the New Jersey Conference for Social Work, has assisted in setting as the subject for their annual December meeting—"The Care of the Indigent Sick in New Jersey". On this problem the State Society and State Relief Administration have already made advanced progress.

It is the belief of this Committee that there are sufficient brains and team work in the physicians' societies and other health service organizations to meet the challenge of the present day, although it means that the individual physician must add to his care of his individual patients, the extra burden of community health problems.

Let our New Jersey Medical Society lead the way in this respect.

In presenting this report your Committee realizes that it is only making a beginning in coöperative efforts in public health matters and respectfully suggests that our work be continued.

Respectfully submitted,
Wm. G. Schauffler, Chairman*
J. Shapiro
Stanley H. Nichols, Secretary
F. C. Johnson
Julius Levy
Allen G. Ireland

Chairman Hagerty: You have heard the Report of the Committee on Public Health. What is your pleasure?

Dr. Alfred Stahl: I move its acceptance and that it be filed, and the Committee be continued in its work.

The motion was seconded, put to a vote and carried.

Chairman Hagerty: Dr. Marsh, do you care to make your Report now, as Treasurer?

Dr. E. J. Marsh: Mr. President, the Annual Report of the Treasurer has been printed, and was distributed through the House this afternoon, though I don't know how many of you still have copies.

The chief points to speak of, with regard to the securities in the Permanent Fund, which total $15,000 are—well, I suppose you would like to know what they are worth actually, that is, *the book value and the real value,* and I would, too. About $9000 of the $15,000 is worth its face value at any minute, it is absolutely liquid; the Liberty Bonds and the Certificate of Deposit. As for the mortgages, of the Title Mortgage Companies, what they are worth, I don't believe anybody in New Jersey can tell you; I can't, I am sure. If anybody else can, I would be glad to hear from him.

About the items of *expenses* and *receipts,* there is nothing particular to say, but I want to call your attention to the fact, as shown at the bottom of the page, the net deficit on the year's operation has been $5131.72. That, you were told, would be the case when the Budget was adopted last year and the assessment set at $10 instead of $13, as it had been for the previous year. That loss we have been able to carry by drawing on the accumulated balance of last year. Last year we had an operating surplus of something near $6000, but this year we have drawn that down so far that by the end of the year, by December, we will be very close to scraping bottom. I hope we will get over without touching. But it means that it will be impossible to run on the same assessment next year; even with the closest economy, the assessment will have to be raised because we haven't the $5000 balance to run on that we had at the beginning of this year. Having drawn your reservoir dry, you can't count on that any longer.

The only other comment is—that all the ordinary expenses of the Society have been kept well in hand by the different organizations. the regular organizations, but the expenses of the Annual Meeting, last year, ran us into a considerable hole because the receipts of the Program and Arrangements Committee, from exhibitors and advertisers, and so forth, ran so far behind what had been expected and to what we had been accustomed. That accounts for a considerable part of the deficit. Of course, *the essential feature of the deficit was the reduction of the assessment.* That, cannot go further.

If there are any particular items in the report that anybody would like to question, I would be glad to answer; otherwise, that, I think, Mr. Chairman, is all I have to say.

Annual Report of the Treasurer
1933

PERMANENT FUND

DR.

June 1, 1932—	
2 M 1st Liberty Loan 3½% bonds..	$2000.00
4 M 4th Liberty Loan 4¼% bonds..	4000.00
Mortgage Certificates, Investors Title & Mortgage Guarantee Company..	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Company..	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
	$15,000.00

CR.

May 31, 1933—

2 M 1st Liberty Loan 3½% bonds	$2000.00
4 M 4th Liberty Loan 4¼% bonds	4000.00
Mortgage Certificates, Investors Title & Mortgage Guarantee Company	3000.00
Mortgage Certificates, Trenton Mortgage & Title Guarantee Company	3000.00
Certificate of Deposit, First National Bank of Paterson, 3½%	3000.00
	$15,000.00

GENERAL ACCOUNT

Receipts

Balance, June 1, 1932	$29,767.76
Assessment—	
Atlantic $1089.00	
Bergen 2000.00	
Burlington 520.00	
Camden 1535.00	
Cape May 213.00	
Cumberland 490.00	
Essex 8180.50	
Gloucester 353.00	
Hudson 4316.00	
Hunterdon 260.00	
Mercer 1620.00	
Middlesex 1239.50	
Monmouth 1082.25	
Morris 939.00	
Ocean 180.00	
Passaic 2300.00	
Salem 160.00	
Somerset 483.00	
Sussex 190.00	
Union 2278.00	
Warren 233.00	
	29,661.25
Interest	1,376.28
Publication	6,741.08
Associate Members	150.00
Miscellaneous	7.00
	$67,703.37

Payments

For Publication Committee		$13,557.07
" Welfare Committee		621.70
" Trustees and special committees		86.00
" Executive Department:		
Salaries	$14,000.00	
Travel	1,994.84	
Office and rent	3,645.17	
		19,640.01
" Treasurer's office		70.82
" Secretary's office:		
Salary	$ 1500.00	
Expenses	2411.55	
		3,911.55
" Printing, postage and stationery		1,867.01
" Annual Meeting, 1932:		
Program Committee, extra	$ 968.76	
Credentials Committee	381.26	
Scientific Exhibit	678.40	
Section meetings	95.13	
Guests	36.75	
		2,160.30
" Tri-State Conference		142.90
" County Secretaries' meeting		147.23
" R. R. fares of Delegates:		
To A. M. A. Meeting	$ 439.89	
Pan-American Congress	121.60	
		561.49
" Legal services		150.00
Refund of insurance premium		20.00
Atlantic City National Bank failure		131.25
Balance, May 31, 1933		24,636.04
		$67,703.37

SUMMARY

Balance, June 1, 1932	$29,767.76
Receipts	37,935.61
Expenses	43,067.33
Balance, May 31, 1933	24,636.04
Net deficit	5,131.72

Respectfully submitted,
E. J. Marsh,
Treasurer.

Chairman Hagerty: Are there any questions to be asked of the Treasurer with regard to the report? It not, the Chair will order that it be received and placed on file.

The next order of business is the Report of the Committee on Workmen's Compensation Law, Dr. George Sommer, Chairman. (No response.)

We shall now have the report of the Committee on Maternal Care. Is Dr. Bingham present, or Dr. Mount?

Dr. Walter B. Mount: Mr. Chairman, Dr. Bingham asked me to read this report.

Report of the Committee on Maternal Welfare

Considerable interest has been shown in the various counties in organizing maternal welfare commissions and the work is progressing as well as can be expected. All of the counties except Warren are now represented in this maternal welfare work and in time we hope to report improvement in statistics in maternity in the State.

There were 2 meetings of the State Committee with the various county commissions last year. The first was held in Atlantic City on June 15 and while not very largely attended proved to be of great interest to members present.

The second meeting was held in Newark December 1, 1932, and was attended by 30 men representing 10 counties: Bergen, Burlington, Camden, Cape May, Essex, Hudson, Monmouth, Passaic, Salem and Somerset. After hearing reports from representatives of the various counties, dinner was served by the Essex County Maternal Welfare Commission for the out-of-town guests. After dinner, Dr. J. H. Stander of the Cornell Medical Center gave a talk on "Nephritis Complicating Pregnancy", which was enjoyed by all.

The next meeting will be held at Atlantic City on Friday afternoon, June 9, 1933, when Dr. Philip F. Williams, of Philadelphia, will give a talk on "The Avoidable Factors in Maternal Mortality". Reports from the various county maternal welfare commissions will follow and a full attendance is urged.

On looking over the New Jersey State statistics for the past 10 years, we find that ¾ of the maternal deaths are due to preventable causes. Sepsis stands first in the causes of death each year. Toxemia is next with ½ as many. Accidents of labor and hemorrhage follow closely. Sudden deaths

and accidents of pregnancy come last. There are also altogether too many stillbirths. When the results of the last 5 years are compared with the preceding 5 years, we find that in 10 counties statistics have been slightly improved and in 11 counties they are slightly worse. **There is no doubt** but that these statistics can be improved and right here is a great field for constructive work.

The Committee recommends no fads nor complicated methods of procedure but it does emphasize 4 points.

(1) Better prenatal care—meaning prenatal care for more patients and more comprehensive care for each patient, prenatal care which anticipates complications by preventive treatment before symptoms appear. It is not sufficient to practice watchful waiting and to treat the complications as they arise. Here is a line of work which every county can improve.

(2) Better technic in the care of even a normal case. With a little more thought and more attention to details better results will be obtained.

(3) Better obstetric judgment by which cases are steered along a normal course and fewer radical operations attempted. We recommend trying to keep the normal case normal with operative procedures reduced to the minimum.

(4) Early consultation in complicated cases. Much improvement will be made in final results if this idea is carried out and every hospital should have rules requiring consultation in certain cases. This feature is imperative and is urgently recommended.

Maternal Welfare Committee: Dr. Theodore Teimer, Dr. George Van Voris Warner, Dr. P. DuBois Bunting, Dr. John F. Condon, Dr. Carl H. Ill, Dr. Walter B. Mount.

A. W. Bingham,
Chairman.

Chairman Hagerty: Are there any remarks on the Report of the Committee on Maternal Welfare? If not, the Report will be received and placed on file.

The next order of business is the Report of the Committee on Investigation of State Medicine, Dr. Francis Todd, Chairman. (No response.)

Report of the Delegates to the American Medical Association.

As you all know, this year's meeting of the American Medical Association has not yet been held, so there is as yet no report. I happen to be one of the Delegates to the meeting, and suggest that a report may be sent later for publication.

(Report Submitted Later)

Meeting of the American Medical Association
Report of the Delegates

The meeting of the American Medical Association this year having followed that of our own State Medical Society, it has been felt that a report of the Committee at this time would be of greater interest and value to the members than later, reserving the official report for our next Annual Meeting. At the same time, because the meetings for several years have been held in the West and South, so that but few of our members have had the opportunity of attending, it has been thought advisable to submit a more comprehensive report.

The Delegates wish at the outset to express their appreciation for the privilege of participating in the deliberations of the House of Delegates, which were carried out in the most dignified and business-like manner, under the capable and efficient guidance of Dr. Olin West, Secretary, and Dr. Warnshuis, Speaker of the House. The reëlection of these 2 officials, without opposition, testified to their ability in carrying out the details of their respective offices.

It is a stimulating experience to take part in the discussion of questions involving the welfare of the profession by a group of men representing every State in the Union, the foreign possessions (Alaska, Hawaii, Puerto Rico, the Philippines, and the Canal Zone), the Army, Navy, and Public Health Service, and representatives of the various sections of the Association, totaling 175 members. And, as evidence of their interest and zeal in the work, it may be stated that 168 members were present at the opening meeting, and at the last meeting, when election of officers was held, 163 members were present. It must be apparent that deferring election of officers to the last day serves to maintain the interest of the members, and this fact might well be considered by our State Society.

Many of the Delegates have been members of the House several years. Dr. Heckel, who had been Chairman of the Board of Trustees until this year, has been a member 25 years, while not a few have been in continuous attendance more than 20 years. This long acquaintance with the rules and business of the House, combined with the fact that most of the Delegates have held positions of responsibility in their State Societies, enables one to judge the caliber of the House of Delegates and to feel certain that any questions presented for consideration will have the benefit of thoughtful and ripened experience.

One frequently hears the questions: "Why have a State Medical Society?" and "Of what use is the American Medical Association?", and a very excellent answer to all such questions will be found in reviewing the activities of the Association. The report of the Board of Trustees contains well-considered opinions upon such subjects as: Legal Medicine and Legislation, Health and Public Instruction, Medical Economics, including contract practice, group hospitalization, Workmen's Compensation and group practice. The report of the Judicial Council, with its recommendation upon contract practice, which was adopted by the House, is important enough to be stated here:

"By the term 'contract practice' as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate *per capita*.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is under-bidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of his employment make it impossible to render adequate service to his patients. (7) When the contract, because of any of its provisions or practical results, is contrary to sound public policy.

Each contract should be considered on its own merits and in the light of surrounding conditions.

Judgment should not be obscured by immediate, temporary, or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole."

The work of the Council on Medical Education and Hospitals, which during the last 30 years has been engaged in raising the standards of Medical Education and Hospitals; of the Council on Pharmacy and Chemistry, which exercises vigilant supervision over drugs, surgical instruments and appliances, foods, beverages, etc., and which investigates 12,000 questions and complaints annually; the publication of the Journal, conceded to be the outstanding medical journal of the world—and it should be remembered that the fund received through publication of the Journal enables the Association to carry on its multitudinous activities; the labors of the officers in their efforts to aid and coördinate the work of the profession throughout the country; all of these activities and more must convince one that a very earnest and sincere effort to conserve the interests of the profession and the public is being made.

Appreciation of the zeal and devotion of the retiring President, Dr. E. H. Cary, cannot be withheld when it is recalled that he traveled over 100,000 miles throughout the country during his term of office, visiting and addressing State and County Societies and National and State Legislatures, and that he was away from his office 11 months in 2 years.

Some of the more specific matters considered and approved by the House of Delegates were: the objections of Presidents Cary and Lewis, strongly expressed, to the hospitalization of veterans for non-service connected disabilities; adoption of the motion, made by Dr. Leigh, of Virginia, that Presidents of constituent societies be made *ex officio* members of the House of Delegates; the Speaker's reference to the value of full reports of sessions of the House, to State Societies; action of the Trustees in continuing to send the Journal to members, when delinquent, on promise to pay (the By-Laws provide that a Fellow who, for one year, has failed to pay his annual Fellowship dues, shall forfeit his Fellowship 30 days after notice of his delinquency has been mailed to his last known address); the decision on the status of medical students educated abroad, that the license to practice must be obtained in the countries in which they received their medical education; the suggestion to do away with State Board examinations and accept certificates of Medical Colleges; a plan for regulation and control of Specialism by the American Medical Association; and tabling of the resolution calling for investigation of Birth Control. (A similar resolution met with the same fate last year.)

This is part of the large volume of business presented to the House during the 4 days' session, all of which received thorough consideration and was disposed of to the satisfaction of the Delegates.

The sessions were honored at each meeting by visits of former officers of the Association, who received from the Delegates enthusiastic evidences of appreciation of their efforts in behalf of organized medicine. Drs. Judd, Work, Matas and Simmons, former Editor of the Journal, were present this year.

The programs for the scientific sessions were extremely interesting and comprehensive, and the meetings were well attended, while the scientific exhibit, as heretofore, proved the most interesting feature of the meeting. The arrangements for holding meetings and housing the exhibit were perfect, and those privileged to attend received an excellent impression of recent progress in Medicine, Surgery and Pathology. Especial attention this year was devoted to poliomyelitis; cancer; endocrine disturbances and their effects upon growth and bone pathology; and the value of cholecystograms and urograms in demonstrating pathology of the biliary and urinary tract.

Quoting the report of the Committee: "The Committee cannot commend too highly the appropriate arrangements, general and special, the excellent management, the instructiveness, and the scientific as well as practical value of the exhibit * * * and modern methods and devices for the visualization of the most recent advances in medicine."

We cannot fail to mention the successful efforts of the County and State Society Committees in perfecting the arrangements for carrying out the manifold activities of the Convention, nor to express thanks for the generous hospitality in entertaining the Delegates and members of the Women's Auxiliary.

The general attendance far exceeded that of the Convention held last year.

(Signed) John F. Hagerty
Walt P. Conaway
Ephraim R. Mulford
Bert S. Pollak

The next order of business is the Report of State Board of Medical Examiners of New Jersey, Dr. James J. McGuire, Secretary.

Dr. McGuire read the report of the State Board of Medical Examiners.

Report of the State Board of Medical Examiners of New Jersey

James J. McGuire, M.D., Secretary

The following is a brief report of the activities of the State Board of Medical Examiners of New Jersey during the past year:

Licenses. The Board issued 271 licenses to physicians and surgeons; of which number, 113 were by examination and 158 by endorsement of licenses from other States or the diploma of the National Board of Medical Examiners.

To osteopathic physicians, 39 licenses were issued; 33 by examination and 6 by endorsement.

Of chiropractors, 7 were admitted to the examination under one of the exemptions contained in Section 11 of the Limited License law, passed the examination and received certificates of license; and 2 chiropractors were licensed under the Spanish-American War Veterans' exemption, making a total of 9 chiropractors licensed.

Of midwives, 6 were licensed to practice after passing the examination of the Board.

Chiropodists, 55 in number, were licensed to practice. The number of chiropody applicants has been steadily increasing since the Act was amended in 1930 to raise the educational standard. The Board expects to have at least 100 or more candidates for the June chiropody examination.

Revocation of licenses. The license of 1 midwife was revoked for conviction of the crime of criminal abortion, and the license of 1 physician was revoked for chronic and persistent inebricty.

Court decisions. An applicant who had been refused endorsement of his license from another State because he was not a graduate of a College on the approved list of the Board, applied to the

Supreme Court for a writ of mandamus. After reviewing the case, the Supreme Court held:

"It appears, therefore, that although, under the stipulation, the standard for requirements for license in the State of Illinois is substantially equal to the standard of requirements here, nevertheless, in this particular instance a license was granted there in large part based on the credentials of an institution of which the Board of this State does not approve. There is no partisanship or selective prohibition laid against the candidate. The fact that has barred him would be likewise applicable against anyone, man or woman, or any race or creed, whose professional training had not measured up to the standard set by the New Jersey Board. We think that the action of the Board was not on an abuse of discretion; that on the contrary it was within the legitimate field of Board determination."

The Court then concluded that neither of the writs asked for by the defendant should be granted and the rule was discharged.

Another important decision was in regard to the imprisonment of a female under the Medical Practice Act. A female defendant was found guilty of practicing medicine without a license, refused to pay the penalty and when she was committed to jail her attorney obtained a writ of habeas corpus from the Judge of the Common Pleas Court. An appeal to the Supreme Court was taken by the Attorney General and the order of discharge was reversed and the defendant was ordered to be remanded to the custody of the Sheriff to carry out the penalty imposed by the District Court.

Prosecutions. Attention has been given to as many of the complaints received as the funds of the Board would permit, and the Board is continuing to investigate a number of the complaints.

Court Cases

Convicted, pleaded guilty or settled	51	
Lost	5	
Won by Board, appeal to Supreme Court taken by defendant	2	
Listed in Court and not yet tried	31	
	—	89

Decisions of Higher Courts

Lost by Board—trial court reversed and new trial ordered—case retried and decision reserved	1	
Case marked not moved in trial court—appeal to Supreme Court by Board—trial ordered by Supreme Court	1	
Writ of Mandamus to compel Board to issue license not granted by Supreme Court	1	
Order of Common Pleas Court discharging female defendant from custody—appeal taken by Board—Supreme Court reversed the order of discharge and ordered defendant recommitted	1	
	—	4

Hearings for Revocation of License

Complaint dismissed	3	
License revoked	2	
Cases pending	1	
	—	6
		—
		99

Analysis of Inspections and Investigations

Total number of investigations and inspections made	205
Total number of visits made and treatments received in making the investigations and inspections	1176
Average number of visits per investigation	5.74

Chairman Hagerty: Are there any comments on the Report of the Medical Examiners? If not, it will be received and placed on file.

Will Dr. Cosgrove make a report for the Committee on Hospitals and Medical Education?

Dr. Samuel A. Cosgrove read the Report of the Committee on Hospitals and Medical Education.

Report of the Chairman of the Committee on Hospitals and Medical Education of the Medical Society of New Jersey for 1932-33

To the President, Officers, Delegates and Members of the Medical Society of New Jersey:

The work of this Committee naturally falls into 2 parts, that dealing with: (1) matters pertaining to hospitals, dispensaries, staff regulations, etc., and (2) matters having directly to do with postgraduate medical education in our State.

Both of these matters have been covered fairly thoroughly in the Presessional Report already published in the May issue of the Journal of the Society, in such detail that it is only necessary at this time to amplify it by bringing the statistical information up to date, and to crystallize certain conclusions and recommendations, based on the experience of the Committee in the past, for the guidance of the Society and its Committee in the future.

Final statistics show 20 courses operated in 13 centers with a total registration of 495, which is second only to the year 1931-32, in which 25 courses were operated in 13 centers with a total registration of 822. That year represented the first year in which the present very complete organization on the part of the University, was in fullest operation, whereas the economic conditions were not quite so hard as they have been this year. It is felt that the interest exhibited and the number of registrations this year, is an excellent record under the economic conditions which have obtained.

The subjects covered have been Medicine, Surgery, Applied Neurology, Visceral Neurology, Electrocardiography, Ophthalmology, Pediatrics, Industrial and Traumatic Surgery, with certain special variants of several of these broad topics. Fifty-three lecturers have contributed to the 20 courses, of whom 28 were drawn from New York, 21 from Philadelphia, 2 from Boston, 1 from Newark and 1 from Morristown.

The gross income received from the 20 courses operated was $7000. The direct expense of the courses, embracing fees and traveling expenses to lecturers, printing and mimeographing, stenographic service, telephone expenses and traveling expenses of the University staff, amounted to $5918.23, leaving a cash balance of $1081.77 to offset an expense to the University consisting of the salary of 1 full-time University Extension Staff member, the occasional services of 7 additional members of the University Extension Staff, the salary of a half-time stenographer, general office overhead including specific items of postage, telephone, registrar service and general supervision. In all, it is roughly estimated that the University has directly contributed, over and above the small net receipts for the operation of the courses, not less than $5000 in services and general overhead expenses. The details of these statistics are exhibited in the charts appended hereto.

In connection with the work of the courses during the current year, mention should be made of the coöperation of many County Societies in acceding to the request of the Committee to make their local committees of a more or less permanent character so that the ground work for next year may be carried on through the Summer, and appreciation expressed for the general interest and helpful coöperation which local committees everywhere have accorded the representatives of the University and of your Committee in forwarding the responsibilities and work of your Committee.

Similar recognition and appreciation is due the splendid coöperation of the lecturers who have so fairly and cheerfully submitted to the reduction of their remuneration for services rendered to us; for their promptness in keeping their engagements; and for the high type of instruction exhibited in their work.

Note should be made also of the increased tendency exhibited in this year's courses of having several courses and portions of other courses integrated and coördinated in their presentation by a single lecturer rather than by a number of lecturers. This tendency should, it is believed, be further carried out in subsequent courses.

In addition to the acknowledgment made of Dr. Satchwell's excellent work contained in the Pre-Sessional Report, merited acknowledgment is also due Dr. Lippincott, President of the Society; Dr.

CHART A

POST-GRADUATE MEDICAL PROGRAM

1932-1933

Centers and Courses	Initial Registrations ($15.00)	Duplicate Registrations ($10.00)	Interns ($5.00)	Totals	
(1) Atlantic City (Atlantic & Cape May Counties)					
(1) Medicine	21	..	..	21	
(2) Applied Neurology*	7	12	10	29	
				—	50
(2) Bridgeton (Cumberland & Salem Counties)					
(1) Medicine and Surgery	24	..	..		24
(3) Camden (Camden & Gloucester Counties)					
(1) Recent Advances in Medicine and Surgery	32	..	..		32
(4) Elizabeth (Union County)					
(1) Recent Advances in Medicine and Surgery	32	..	..		32
(5) Hackensack (Bergen County)					
(1) Applied Neurology	20	3	3		26
(6) Mt. Holly (Burlington County)					
(1) Medicine	17	1	..		18
(7) Newark (Essex County)					
(1) Visceral Neurology	26	1	..	27	
(2) Electrocardiography	24	5	..	29	
(3) Medicine	18	5	..	23	
(4) Ophthalmology	22	2	..	24	
(5) Pediatrics	15	5	..	20	
				—	123
(8) Newton (Sussex County)					
(1) Pediatrics	14	3	..		17
(9) Paterson (Passaic County)					
(1) Visceral Neurology*	17	3	1		21
(10) Perth Amboy (Middlesex County)					
(1) Medicine	32	..	..		32
(11) Skillman-Somerville (Somerset County)					
(1) Organic Neurology (Skillman)	26	..	..	26	
(2) Industrial and Traumatic Surgery (Somerville)	7	8	..	15	
				—	41
(12) Trenton (Mercer County)					
(1) Surgery	27	6	..	33	
(2) Medicine	32	3	..	35	
				—	68
(13) Washington (Warren County)					
(1) Recent Advances in Medicine and Surgery	11	..	..		11
Totals	424	57	14		495

*Registrations incomplete.

13 centers

20 courses

William J. Carrington, of Atlantic City; and Dr. Henry K. Mohler, Professor of Medicine in the Jefferson Medical College and Medical Director of the Jefferson Medical College Hospital, in Philadelphia, for their assiduous help to the Committee.

Conclusions. Your Committee has had an active year and has endeavored to prosecute the particular duties laid upon it by the Society. In pursuance thereof it has submitted a report on certain phases of hospital and staff regulations, which is the result of much intensive study by a subcommittee under the Chairmanship of Dr. William J. Carrington.

It has also carried out in conjunction with the highly efficient operation of the University Extension Division of Rutgers University, a program of Post-Graduate lectures throughout the State, the interest in and the success of which has been truly remarkable, considering the strongly adverse economic conditions under which the membership of the Society has existed during the past year.

The picture of the Post-Graduate work in the State would not be complete without recognition of several excellent courses which were not conducted under the State Society's auspices, but which have been a distinct contribution to the welfare of the profession in the State. Notable examples of this have been the special course of lectures given under the auspices of the Jersey City Medical Center; a fine course under the auspices of the Hudson County Medical Society; a course in tuberculosis given under the auspices of the Hudson County Tuberculosis League; a course given in Passaic County; a most helpful week of clinics and exhibitions by the Hackensack Hospital; and perhaps other courses of which your Committee has no record. All such efforts fit in the broad pattern of noteworthy ambition on the part of the membership of the Society to maintain contact with the most up-to-date advances in medicine, to the end of better serving the citizenry of New Jersey.

Recommendations

(1) The report embracing hospital and staff regulations of the Sub-Committee is before you for action through the Board of Trustees. It has been printed in full in the Pre-Sessional Report, besides which copies are in the hands of all the Trustees and all members of the Committee. No recommendation is made by the Chairman as to your action in this matter;

(2) Your Committee does recommend the continuance of the annual courses in Post-Graduate Medicine as a joint collaboration between this Society and the University Extension Division of Rutgers University, under such arrangement of details as shall be necessary in the judgment of your Committee and the University authorities, as indicated by current general economic conditions, the financial resources of the University and the best interest of the local subscribers;

(3) That to this end all Component Societies be enjoined to support this Society's program of State-Wide Post-Graduate Medical Education, so that the more populous Component Societies may subsidize the State program to such extent as, while not unjust to their own interests, will permit making the benefit of these courses available to component societies in the less populous sections of the State;

(4) That the Society adopt resolutions expressing its conviction as to the great value to its members of this program of Post-Graduate Medical Education; its appreciation of the fact that the prosecution of such a State-wide program therof would be impossible without the helpful collaboration of the University Extension Division of Rutgers University; its thanks and appreciation to the Regents of Rutgers University for making this collaboration possible and to Professors Miller, Chaffee and Light of the Extension Division for their own carrying out of this collaboration; and directing the Secretary to send a copy of these resolutions to the Chairman of the Board of Regents of Rutgers University, to the President of the University, and to the Director of the University Extension Division thereof.

Respectfully submitted,

S. A. Cosgrove, Chairman.

June 6, 1933.

13 centers
20 courses

CHART B

POST-GRADUATE MEDICAL PROGRAM

1932-1933

	Opening Date	Closing Date	Time	Center	Course
(1)	November 1	December 6	8.30 p. m.	Skillman	Organic Neurology
(2)	January 19	February 23	8.30 p. m.	Elizabeth	Recent Advances in Medicine & Surgery
(3)	February 28	April 4	8.30 p. m.	Newark	Visceral Neurology
(4)	March 1	April 12	4.00 p. m.	Camden	Recent Advances in Medicine & Surgery
(5)	March 1	April 12	8.30 p. m.	Atlantic City	Medicine
(6)	March 2	April 6	4.00 p. m.	Perth Amboy	Medicine
(7)	March 2	April 27	4.30 p. m.	Newark	Electrocardiography
(8)	March 3	April 7	8.30 p. m.	Newark	Medicine
(9)	March 9	April 13	8.30 p. m.	Washington	Recent Advances in Medicine & Surgery
(10)	March 16	April 20	9.00 p. m.	Hackensack	Applied Neurology
(11)	March 21	April 25	8.30 p. m.	Somerville	Industrial and Traumatic Surgery
(12)	March 23	April 28	8.30 p. m.	Newark	Ophthalmology
(13)	March 28	May 2	8.30 p. m.	Trenton	Surgery
(14)	March 30	May 4	8.30 p. m.	Trenton	Medicine
(15)	April 6	May 11	4.00 p. m.	Mt. Holly	Medicine
(16)	April 11	May 16	8.30 p. m.	Newark	Pediatrics
(17)	April 13	May 18	4.00 p. m.	Bridgeton	Medicine and Surgery
(18)	April 13	May 18	8.30 p. m.	Newton	Pediatrics
(19)	April 19	May 24	8.30 p. m.	Atlantic City	Applied Neurology
(20)	April 25	June 2	9.00 p. m.	Paterson	Visceral Neurology

CHART C

FACULTY

1932-1933

Numbers of doctors who lectured this year, from:

New York	28
Philadelphia	21
Boston	2
Newark	1
Morristown	1
Total number of lecturers	53

Frederick Allen, M.D., Director Psychiatric Institute, Morristown, N. J.

J. Burns Amberson, Jr., M.D., Assistant Professor of Medicine, College of Physicians and Surgeons, Columbia University; Visiting Physician, Tuberculosis Service, Bellevue Hospital, New York.

Jesse O. Arnold, M.D., Professor of Obstetrics, Temple University Medical School, Philadelphia.

W. Wayne Babcock, M.D., F.A.C.S., Professor of Surgery, Temple University Medical School, Philadelphia.

Herbert M. Bergamini, M.D., F.A.C.S., Assistant Clinical Professor of Traumatic Surgery, Columbia University New York Post-Graduate Medical School; Visiting Surgeon, Reconstruction Hospital Unit of the Post-Graduate; Visiting Surgeon, Bellevue Hospital, New York.

H. L. Bockus, M.D., F.A.C.P., Professor of Gastro-enterology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

M. A. Burns, M.D., Associate Professor of Nervous and Mental Diseases, Jefferson Medical College, Philadelphia.

Russell L. Cecil, M.D., Assistant Professor of Clinical Medicine, Cornell University Medical College; Assistant Visiting Physician, Bellevue Hospital, New York.

Hugh Chaplin, M.D., Clinical Professor of Pediatrics, New York University Medical School, New York.

J. Alexander Clarke, M.D., Chief of Out-Patient Department of Immunology, Jefferson Medical School, Philadelphia.

Arthur De Graff, M.D., Professor of Therapeutics, New York University Medical School; Visiting Physician, Cardiac Clinics, Third Medical Division, Bellevue Hospital; Associate Visiting Physician, Bellevue Hospital, New York.

Clarence E. De La Chapelle, M.D., Assistant Professor of Medicine, New York University Medical School, New York.

Roger H. Dennett, M.D., Professor of Pediatrics, Columbia University, New York Post-Graduate Medical School, New York.

Emmett A. Dooley, M.D., F.A.C.S., Assistant Visiting Surgeon, Reconstruction Hospital, Unit of the Post-Graduate; Instructor in Traumatic Surgery, Columbia University New York Post-Graduate Medical School, New York.

John H. Dunnington, M.D., Assistant Director, Institute of Ophthalmology, Presbyterian Hospital; Professor of Ophthalmology, Columbia University, New York.

John F. Erdmann, M.D., Professor of Surgery, Columbia University, New York Post-Graduate Medical School, New York.

Temple Fay, M.D., Professor of Neuro-Surgery, Temple University Medical School, Philadelphia.

Thomas Fitz-Hugh, Jr., M.D., Associate in Medicine, University of Pennsylvania Medical School, Philadelphia.

J. Irving Fort, M.D., Chief of Fracture Service, St. Michael's Hospital and Presbyterian Hospital, Newark, N. J.

Robert T. Frank, M.D., Visiting Gynecologist, Mt. Sinai Hospital, New York.

Charles H. Frazier, M.D., Professor of Neuro-Surgery, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Emanuel D. Friedman, M.D., Professor of Neurology, New York University Medical School, New York.

Vaughn C. Garner, M.D., Assistant Professor of Dermatology and Syphilology, University of Pennsylvania Medical School, Philadelphia.

John C. Gittings, M.D., Professor of Pediatrics, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Harry Gold, M.D., Assistant Professor of Pharmacology, Cornell University Medical College; Associate Physician and Chief of Cardiac Clinics, Beth Israel Hospital, New York.

David Goldblatt, M.D., F.A.C.S., Instructor in Traumatic Surgery, Columbia University New York Post-Graduate Medical School; Assistant Visiting Surgeon, Reconstruction Hospital Unit of the Post-Graduate, New York.

William Goldring, M.D., Assistant Professor of Clinical Medicine, New York University Medical School, New York.

Barton Cook Hirst, M.D., Professor of Obstetrics, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Frederick C. Holden, M.D., F.A.C.S., Professor of Obstetrics and Gynecology, New York University Medical School, New York.

Thomas H. Johnson, M.D., Surgeon, Institute of Ophthalmology, Presbyterian Hospital; Instructor in Ophthalmology, Columbia University, New York.

Elliott P. Joslin, M.D., Clinical Professor of Medicine, Harvard University Medical School, Boston, Mass.

Richard A. Kern, M.D., Assistant Professor of Medicine, University of Pennsylvania Medical School, Philadelphia.

Edward J. Klopp, M.D., Professor of Surgery, Jefferson Medical College, Philadelphia.

Frank C. Knowles, M.D., Professor of Dermatology, Jefferson Medical College, Philadelphia.

John A. Kolmer, M.D., Professor of Medicine, Temple University Medical School, Philadelphia.

Frank H. Lahey, M.D., Visiting Surgeon, Deaconess and New England Baptist Hospitals; Director of Lahey Clinic, Boston, Mass.

Willis W. Lasher, M.D., F.A.C.S., Assistant Professor of Traumatic Surgery, Columbia University New York Post-Graduate Medical School; Assistant Visiting Surgeon, Reconstruction Hospital Unit of the Post-Graduate, New York.

Edward M. Livingston, M.D., Assistant Visiting Surgeon, Bellevue Hospital; Instructor in Surgery, New York University Medical School, New York.

John D. Lyttle, M.D., Assistant Professor of Diseases of Children, Columbia University (P. & S.), New York.

Thomas McCrae, M.D., Professor of Medicine, Jefferson Medical College, Philadelphia.

John J. Moorhead, M.D., F.A.C.S., Professor of Surgery, New York Post-Graduate Medical School, Columbia University; Surgical Director, Reconstruction Hospital Unit, New York.

George P. Muller, M.D., Professor of Clinical Surgery, University of Pennsylvania Medical School, Philadelphia.

George E. Pfahler, M.D., Professor of Radiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Elaine P. Ralli, M.D., Assistant Clinical Professor of Medicine, New York University Medical School, New York.

Martin E. Rehfuss, M.D., Associate Professor of Medicine, Jefferson Medical College, Philadelphia.

Henry H. Ritter, M.D., F.A.C.S., Assistant Professor of Traumatic Surgery, Columbia University New York Post-Graduate Medical School; Visiting Surgeon, Reconstruction Hospital Unit of the Post-Graduate, New York.

Bela Schick, M.D., Director of Pediatrics, Mt. Sinai Hospital, New York.

Charles Hendee Smith, M.D., Professor of Pediatrics, New York University Medical School; Director of Pediatric Service, Bellevue Hospital, New York.

Harry V. Spaulding, M.D., F.A.C.S., Assistant Visiting Surgeon, Reconstruction Hospital Unit of the Post-Graduate, New York.

E. A. Spieel, M.D., Professor of Applied and Experimental Neurology, Temple University Medical School, Philadelphia; Docent of the University of Vienna.

William D. Stroud, M.D., Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

Lucy Porter Sutton, M.D., Assistant Professor of Pediatrics, New York University Medical School, New York.

Ira S. Wile, M.D., Associate in Pediatrics, Mt. Sinai Hospital, New York.

CHART D

POST-GRADUATE MEDICAL PROGRAM
FINANCIAL REPORT

Academic Year—1932-1933

Field income:		
Twenty Classes		
424 Initial registrations @ $15.00	$6360.00	
57 Duplicate registrations @ $10.00	570.00	
14 Intern registrations @ $ 5.00	70.00	
		$7000.00
Direct Field Expenses:		
120 lectures @ $35.00 each	$4200.00	
Travel expenses of lecturers	878.23	
Printing and mimeographing	374.88	
Stenographic service and telephone expenses of the University Technical Advisor	51.37	
Travel expenses of University Extension Staff	413.75	
		$5918.23
Balance		$1081.77

This is all that is left to apply toward the salary of one full-time University Extension Staff man for post-graduate medical instruction, together with 7 additional members of the University Extension Staff who had to give occasional service in connection with this project. Other expenses directly chargeable to the project include one half-time stenographer and the various office overhead consisting of all postage for medical literature, telephone, registrar service, accounting and general supervision.

CHART E

POST-GRADUATE MEDICAL PROGRAM
1929-1930

Center	County	Course	$30.00 Registrations	Internes ($10.00)	Totals	
Atlantic City	Atlantic and Cape May	Medicine	25	9		34
Asbury Park	Monmouth	Medicine—Special	26	3		29
Bridgeton	Cumberland and Salem	Medicine	27			27
Camden	Camden and Gloucester					
Elizabeth	Union					
Hackensack	Bergen					
Jersey City	Hudson	Medicine	61*	2	63	
		Surgery	27	2	29	
					—	72
Mt. Holly	Burlington					
Newark	Essex	Medicine	45**	6		51
New Brunswick and Perth Amboy	Middlesex	Medicine—Special	28			28
Newton	Sussex					
Paterson	Passaic	Medicine	34	1	35	
		Surgery	25		25	
					—	60
Somerville	Somerset	Medicine—Special	28	1		29
Trenton	Mercer	Medicine	33		33	
		Surgery	32		32	
					—	65
Washington	Warren					
		Totals	391	24		415

* one $12 registration
** one $25 registration

1930-1931

Center	County	Course	$30.00 Registrations	Internes ($10.00)	Totals	
Atlantic City	Atlantic and Cape May	Newer Drug Therapy	18	9		27
Asbury Park	Monmouth					
Bridgeton	Cumberland and Salem	Gynecology & O. B.	14			14
Camden	Camden and Gloucester	Cardiac and Gastroenterology	21			21
Elizabeth	Union	Pediatrics	20	4	24	
		Gastroenterology	19		19	
					—	43
Hackensack	Bergen	Gynecology & O. B.	30	1		31
Jersey City	Hudson	Obstetrics	18	2	20	
		Gastroenterology	16		16	
					—	36
Mt. Holly	Burlington	O. B., Cardiac, Gastroenterology & Pediatrics	15			15
Newark	Essex	Pediatrics	25	2	27	
		Cardiac	17	6	23	
		Gastroenterology	18	3	21	
					—	71
New Brunswick and Perth Amboy	Middlesex	Newer Drug Therapy and Fractures	15			15
Newton	Sussex	Gynecology & O. B.	15			15
Paterson	Passaic	Gastroenterology	31	1		32
Somerville	Somerset	Gastroenterology	18			18
Trenton	Mercer	Newer Drug Therapy	10		10	
		Gynecology	20	1	21	
					—	31
Washington	Warren	General Medicine	12			12
		Totals	352	29		381

1931-1932

Center	County	Course	$15.00 Registrations	$10.00 Registrations	Internes ($5.00)	Total	
Atlantic City	Atlantic and Cape May	O. B. & Gynecology	20	1	7	28	
		Medicine and Surgery	26	6	10	42	
						—	70
Asbury Park	Monmouth						
Bridgeton	Cumberland and Salem	Medicine and Surgery	25				25
Camden	Camden and Gloucester	Recent Advances in Medicine and Surgery	45		1		46
Elizabeth	Union						
Hackensack	Bergen	Medicine and Newer Drug Therapy	20	5		25	
		Fractures & Traum. Surgery	11	1	1	13	
						—	38
Jersey City	Hudson	Medicine	44	1	2	47	
		Gynecology	27	21	2	50	
						—	97
Mt. Holly	Burlington	Newer Drug Therapy	20	1			21
Newark	Essex	Gynecology	107	3	2	112	
		App. Neurology—Sec. I	35		1	36	
		App. Neurology—Sec. II	37			37	
		Pediatrics	32	4	1	37	
		Medicine	21	12	1	34	
		Fractures	6	7		13	
						—	269
New Brunswick and Perth Amboy	Middlesex	Medicine and Surgery	32		1		33
Newton	Sussex	Fractures and Newer Drug Therapy	13				13
Paterson	Passaic	Applied Neurology	24	14	3	41	
		Gynecology and O. B.	34	2	6	42	
						—	83
Somerville	Somerset	Recent Adv. in Medicine and Surgery	25			25	
		Gynecology, O. B. & Ped.	3	12		15	
						—	40

Center	County	Course	$15.00 Registrations	$10.00 Registrations	Internes ($5.00)	Total
Trenton	Mercer	Gastroenterology	24	1		25
		Medicine	16	9		25
		Pediatrics	12	4	1	17
						— 67
Washington	Warren	Medicine	18	1	1	20
		Totals	675	105	40	822

1932-1933

Center	County	Course	$15.00 Registrations	$10.00 Registrations	Internes ($5.00)	Total
Atlantic City	Atlantic and Cape May	Medicine	21			21
		Applied Neurology*	7	8	10	25
						— 46
Asbury Park	Monmouth					
Bridgeton	Cumberland and Salem	Medicine and Surgery	24			24
Camden	Camden and Gloucester	Recent Adv. in Medicine and Surgery	32			32
Elizabeth	Union	Medicine and Surgery	32			32
Hackensack	Bergen	Applied Neurology	20	3	3	26
Jersey City	Hudson					
Mt. Holly	Burlington	Medicine	17	1		18
Newark	Essex	Visceral Neurology	26	1		27
		Electrocardiography	24	5		29
		Medicine	18	5		23
		Ophthalmology	22	2		24
		Pediatrics	15	5		20
						— 123
New Brunswick and Perth Amboy	Middlesex	Medicine	32			32
Newton	Sussex	Pediatrics	14	3		17
Paterson	Passaic	Visceral Neurology*	13	2	1	16
Somerville	Somerset	Organic Neurology†	26			26
		Traumatic Surgery	7	8		15
						— 41
Trenton	Mercer	Medicine	32	3		35
		Surgery	27	6		33
						— 68
Washington	Warren	Medicine and Surgery	11			11
		Totals	420	52	14	*486

* Registrations incomplete
† Held at Skillman, N. J.

	1929-1930	1930-1931	1931-1932	1932-1933
No. of Centers	9	14	13	13
No. of Courses	12	19	25	20
Registrations	415	381	822	486 (incomplete)

President Lippincott took the chair.

President Lippincott: You have heard the report of this Committee. What is your wish?

It was regularly moved, seconded and carried, that the Report be received and placed on file and the recommendations of the Committee be adopted.

Acting Secretary Pinneo: In connection with this report, the following resolution has been suggested and is put before you for action, as it follows action of last year, and concerns the reference in this report to the relation of Hospital Staffs and Boards of Directors.

Resolution Regarding Hospital Staffs and Boards of Directors

Whereas this Society at the last Annual Convention demanded by resolution that the rights of the Medical Staff of a Hospital to manage the medical and surgical matters in care of the patients should be recognized by representation of the Staff on the Board of Directors or Executive Committee, or by other such effectual coöperation, therefore, it is now

Further resolved that members of the Medical Society of New Jersey, in mutual support and for the good of all, should not accept positions on the Clinic or Hospital Staffs of

Hospitals which refuse to recognize this principle. *Furthermore,* that any member who accepts such appointment at variance with the rules of his County Society thereby declares himself as *not in good standing in the Society.*

This is put forth and, although it comes from Essex County, is in harmony with the approval of others as well as the Officers of the Society.

Dr. Cosgrove: Mr. President, I have already pointed out, in making my report, that that portion of the work of the Committee on Hospitals and Medical Education will properly come before the convention in the Report of the Board of Trustees. Inasmuch as the resolution which Dr. Pinneo has just introduced may have a very vital tie-up with such recommendations as the Board of Trustees may make in connection therewith, I would suggest that postponement of considering this resolution be made until the Report of the Board of Trustees is received.

President Lippincott: Is that satisfactory to you?

Acting Secretary Pinneo: Well, it was thought this was a matter for the House of Delegates. It doesn't involve any other action or report. Inasmuch as the House of Delegates voted last year a resolution on this topic and this makes it a little more explicit as to what relation the members of this Society bear to such hospitals, even though we don't know of any now, and even though they may be in any case few in numbers, it would be proper for this House of Delegates to act on this resolution.

President Lippincott: I think we had better get this regularly before the House. Do you move the adoption of this resolution?

Acting Secretary Pinneo: I move the adoption of the resolution and that the Secretary communicate this to the counties with the request to the County Societies that every member of the Society be acquainted therewith.

The motion was seconded.

Dr. S. T. Quinn (Union County): I rise to a point of order. My point is that this action is out of order. The matter before the House is the *reports of committees.* I would say that a resolution of this sort would come under the matter of either *unfinished* or *new business,* and it is out of order at this time.

President Lippincott: I think Dr. Quinn's point is well taken. I so rule. This will come up in conjunction with the Report of the Board of Trustees.

Report of the Committee on Finance and Budget, Dr. North.

Report of the Committee on Finance and Budget

Dr. Harry R. North: Your Committee has had a number of meetings and the Budget we decided on today is as follows:

Publication Committee		$14,500
Welfare Committee		750
President's Contingent Fund		2,000
Editor, Executive Secretary, and Field Secretary, salaries and travel expenses (with deductions of 20% and 15% respectively)		13,400
Office Rent		900
Office Expense (deducting a cut of 10% on clerical salary)		2,542
Tri-State Conference		150
Credentials		400
Printing—Transactions	$750	
Official List	550	
Miscellaneous	500	
		$1,800
Treasurer		75
Dr. Morrison—Salary		1,500
" " Office and Travel		1,300
" " Expense at Annual Meeting		900
Secretaries' Conference		150
*A. M. A. (for last year)		500
Scientific Exhibit		500
**Committee on Arrangements		300
Guests		100
Contingent Fund		1,500

*This Committee recommends that after this year, Delegates to the American Medical Association shall pay their own expenses.

**Dr. Olmstead was allowed $800, and he has a credit of $500, presumably, which makes a net cost of $300.

That means that if we have 2900 members next year paying, it will cost the Society $13 per member.

I might say that we had quite a time to get this Report in order. We have on our Committee 1 man who is there ex-officio. The Committee is not entirely in accord. There were 4 votes for it. Dr. Green and myself demurred and wish to put in a Minority Report, stating that *we do not* approve of the reduction in salaries.

President Lippincott: You have heard the Report of this Committee.

Dr. William H. Arcson (Essex County): I move the Majority Report be accepted.

The motion was seconded.

President Lippincott: The motion to adopt this Report is now before the House. Does any Delegate desire to discuss it?*

*(Dr. Reik, not having been present in the House of Delegates during the discussion given below, on the Report of the Committee on Finance and Budget, has filed a protest against some of the statements made by his opponents with reference to his salary and work, and has presented facts and figures tending to prove the inaccuracy and misleading character of those statements.—*J. B. Morrison,* Secretary.)

Dr. Ralph K. Hollinshed (Gloucester County): May we have an explanation of the $2000 for the President's contingent fund?

President Lippincott: I don't see any objections to it.

Dr. North: Do you want me to give the explanation?

President Lippincott: Yes, please; you are on the spot.

Dr. North: I can tell you what I knew of it.

I don't know whether I can give this as well as Dr. Quigley could. I think that a great many people would think this fund is *for legislative work, for a lobbyist.* But I don't feel that way. I think Dr. Quigley feels that he would like to have a couple of thousand dollars because things may happen during the year that you do need money for. I don't believe that Dr. Quigley approves of a paid lobbyist; I don't. Just what he will use the money for, I can't say. But it seemed to us a perfectly legitimate request, and we put the $2000 appropriation in. You will have to get Dr. Quigley to explain further.

Secretary Morrison: Mr. Chairman, I think I can throw a little further light on that. The question arose in the Board of Trustees, as to whether this request of Dr. Quigley's meant a departure from our method of conducting legislation, securing legislation in Trenton during the past 7 years. It was pointed out by some of the members of the Legislature present, that they respected the Medical Society very much for the dignified manner in which its representatives approached them in reference to pending legislation. They have told us repeatedly that they don't want any lobbyists. *Even Dr. Quigley, himself, says he doesn't want a lobbyist.*

We only have an appropriation of $750 for the Welfare Committee. Suppose we want to introduce 2 or 3 bills that would take a lawyer to draw up, it would cost us $200 or $300 a piece or more. It is a contingency of that kind that Dr. Quigley is anticipating.

There will be no paid lobbyist in Trenton; $2000 wouldn't be a drop in the bucket. If we adopt a policy of that kind, the assessment will rise $10, $15, $20 a member. There is nothing like that in view.

President Lippincott: Is that satisfactory, Dr. Hollinshed? Is that satisfactory to the delegates?

The question of approving the Majority Report is before you.

Dr. Ephraim R. Mulford (Burlington County): Mr. President, I don't know just exactly what is the meaning of reducing the salary of the Executive Secretary. I, perhaps, am more familiar than some of the rest of you with the work of our Executive Secretary, having had the honor to be a president of this august body, and having had during and since my term in office a more intimate association with him than most presidents, and I feel that you should weigh very carefully the thing you are about to recommend.

Dr. Reik means to the Medical Society of New Jersey more, perhaps, than any member we have. His work, much of it, has been of a pioneer character. When he came to us 10 years ago, many of the problems that now confront us were not being considered; and many new problems have sprung up since his advent into this field. He has met those problems, face to face, because he knew how, and some of them he has conquered for us—single-handed. Many of us who have substantiated his reports, ourselves knew almost nothing about such things, but we recognized his knowledge and the value of his guidance. I haven't had an opportunity to talk with him about this problem, so I speak as for myself only, but as to that, we have profited from his work more than the amount of his salary. In the legislative field, for instance, when we have wanted or needed an intelligent, accurate interpretation of some Bill, we have had only to consult Dr. Reik to get a reliable understanding of that Bill. When we have wanted representation somewhere, in some other organization, we could depend on Dr. Reik. When we wanted representation in Washington concerning national legislation, we have sent Dr. Reik, as he was always prepared to speak for us on any subject. He has represented us and has been the strength in the Tri-State Medical Society; in fact, that very important organization is entirely the conception of his own brain. Many of the serious problems of organized medicine have been fought out in this Tri-State Medical Conference and some of them have, through his knowledge and ability, been brought forth to a fruitful solution. So, Gentlemen, I ask you to weigh carefully the report that you are about to accept.

In his editorial work, if you remember the Journal of 10 years ago, compare it with the Journal of today, and see where we stand. The New Jersey State Medical Society, and particularly its Journal, stands among those at the top of the heap today, and our standing is recognized by the American Medical Association. It was with great pride that 4 of us have, while President, gone to the American Medical Association Conference of Sec-

retaries and Editors, and it is with just pride that we sat in, realizing that our State is now among the leaders. I ask you again, to please weigh carefully what you are doing.

Dr. J. F. Hagerty (Essex County): I could not, in fairness to myself, nor to the interests of the State Society, which I hold very dear, allow this project to go by uncontested. I can appreciate, I think, as well as anybody here, the necessity for retrenchment at this particular time, but if this reduction in Dr. Reik's salary should mean to the State Society his loss as Executive Secretary and Editor of the Journal, then we are committing a very serious blunder. We are losing the services of a very valuable man, a man who has a talent for the work he is doing, a man who has a talent for editorial work, a man who, I know from my year's experience as President of the State Society, is capable, thoroughgoing, efficient, courteous, helpful at all times to the Officers of the State Society and to the rank and file of the profession of this State.

Nobody, I think, can question the advanced position of our State Society today in the estimation of the profession in this State, in our adjoining States, or in the American Medical Association. We all know how our Society has increased in influence with our neighboring States, brought about through Dr. Reik's organizational ability, and I think the credit for that was due largely to him and his Tri-State Medical Conferences. We are ranked now with New York and Pennsylvania, 2 of the largest States in the Union. The Tri-State Conferences, 3 each year, are presided over, in turn, by New Jersey, New York and Pennsylvania State Society Presidents, and I say, without fear of denial, that the programs arranged under the auspices of the New Jersey State Medical Society are always the very best that are produced by any of the 3 State Societies, and that fact will be acknowledged, I think, without any hesitancy, by the representatives of the New York State Society, or the Pennsylvania State Medical Society; and that is but another of Dr. Reik's achievements.

We know what he has done in the matter of organization of the Annual Conferences of County Society Secretaries and Reporters. The influence of that organization, started and developed almost entirely by him, is now being felt throughout the country. It is appreciated, I know, by the American Medical Association. We have become not only the New Jersey State Medical Society, but a State Society which has an influence throughout the whole country. We men whom you have honored, by appointing us as Delegates to the American Medical Association, know this fact much better than you who have not yet had the same opportunity. I, too, think and I beseech you to listen to the remarks of those who have had intimate contact with Dr. Reik, who have a chance to appreciate his ability, who have a chance to appreciate what he has done for us. What, after all, is a matter of a few dollars if we lose the services of Dr. Reik? And what certainty have we, as I have said to some of you, if we lose his services, that we are going to get somebody as good? I think that is to be considered.

We don't want to act like children in this matter, and we don't want to act thoughtlessly. Whom are you going to get in his place? How do we know that a man of his caliber and his ability, will take the place and do the work he has been doing, for less than he has been doing it or even for the same amount?

I may tell you something that, perhaps I should not say, but until a very few years ago—I have stated this to some others, and I want to be very frank and honest about this matter, because I do appreciate more than some of you can the value of Dr. Reik's services to this State Society—when I became President, I was not on the friendliest terms with Dr. Reik; some little thing had estranged us. But, I was honored by you, the House of Delegates, with the presidency of the State Society, and I had a chance then to learn and to appreciate what Dr. Reik meant to the State Society. *I know that he is worth every cent that he is getting from us and I think it would be very unwise to reduce his salary if it involves the possibility of the loss of his services to the State Society.*

There is another thing I might say to you, though it is somewhat personal. Here is a man no longer youthful, who lost a hand by accident and having abandoned surgery, turned to literary work that he can do and do well, better than any of the rest of us could, I am sure, and better than many whom you will try to secure to replace him. We should not forget that he has labored earnestly and hard, and given to us the best that was in him. Are you fair to him? Those things, I think, should not be forgotten. I beg you to remember those things and I beg you not to act hurriedly and ill-advisedly, but to consider just what Dr. Reik has meant to us, and just where our State Society is today compared with what it was 10 years ago.

Secretary Morrison: Mr. Chairman and Members of the House of Delegates: It

takes a high degree of courage for a man to stand here, as our Ex-President has just done, and tell you that *he was converted from a foe to a friend.* It takes association with Dr. Reik, as nobody in this State Society has had except the men who have "gone through the chairs", to appreciate the enormous amount of work he does, the great ability and tact and judgment and consideration he has given to this job, and his enormous value to the Medical Society of New Jersey.

You all know I am "Reik's friend". Well, I am not speaking to you tonight as "Reik's friend"; I am speaking to you *as a friend of the Medical Society of New Jersey.* If you could go out to Chicago with Reik and myself and the President of this Society, and see the deference that is shown to the representatives of the Medical Society of New Jersey by those associate Editors and Secretaries, you would realize and better understand something of the work that Reik has accomplished in the past 10 years. If you could be present, as the Officers of this Society are, year after year, in the Tri-State Conferences of the 3 Societies which have been referred to, you would see and appreciate the deference and the respect that is shown to Reik as the organizer of this plan, and as the man who has brought about all these tangible results.

As an Editor, I don't know of another State Society Editor in any of these United States that ranks with him in ability—barring none. If his salary is cut, I suspect he will resign.

Let me tell you this: Reik came with us 10 years ago, a man with a record of exceptional ability who had held an international editorial position with a European branch office in France. He accepted the salary we offered him, and he has never asked for a dollar's increase, even during the period of prosperity when our incomes were increasing, up to 1929, and we never paid him a dollar in addition to the initial salary that he had agreed to 10 years ago; but we accepted a voluntary reduction during the time he was sick. That is one of the reasons why he feels that he is worth today every dollar we are paying him. I trust you will weigh this matter carefully before you come to a conclusion.

Dr. Alfred Stahl (Essex County): I want to speak, not as a foe or a friend of anybody; I want to say I am not a foe. I do believe that when we consider that Dr. Reik's salary was the same in 1928 and 1929 as today, everything he needs is from 25 to 35% cheaper; therefore, the same salary today is an increase of 25% to say the least.

In a time when we all are taking cuts ranging from 40% up, I can see no reason why we are not entitled, at least, to see that he does not have an increase.

As to his abilities, there is no question about that. The Editor of such a noble State as New York gets quite a little less and does good work. I believe that it is perfectly within our rights, if we feel that we want to make a retrenchment, to make a cut in the salary of Dr. Reik and some of the employees in his executive office. It seems to me that men in all executive offices are taking decided cuts. The State of New Jersey, I see in this morning's paper, has found it necessary to cut the budget $10,000,000. Every community is reducing their executives' salaries. The executives of railroads are going to be reduced from $75,000 and $100,000 to no less than $17,500, or they are not going to get help from the United States Government.

It seems to me very arbitrary on Dr. Reik's part not to take some reduction. Last year when we went to a deficit of $5000, we asked him to take it voluntarily. Had he done something of that sort, we might have felt different about it, at least not to make it 20%. but he did not. He simply arbitrarily says he will not take any cut.

Dr. S. T. Snedecor (Bergen County): I don't feel that I could go back to Bergen County unless I said something on this report. I know the feeling of the members of the Bergen County Medical Society who have been taking cuts of from 25 to 50% in their income the last few years. They expect us Delegates down here to the State Convention to see that some retrenchment is made in proportion to the cuts they are taking.

When times are hard enough so that we have to begin to support our own doctors and contribute monthly to take care of our own indigent physicians up in our county, it seems too little to ask, as a matter of good sportsmanship and that alone, for the Executive Editor to take a reasonable cut in salary during the time of stress.

Dr. F. W. Pinneo (Essex County): I want to say a word for the doctors who are members of the State Society. As Secretary in Essex County, I know too well what these times mean to the doctors. Indeed, we may say that this new proposition from the State Relief Administration to the medical profession of New Jersey, to partially compensate physicians for their care of the indigent sick, in ordinary times would not be thought of by us. We stand for the dignity of what the medical profession has always done for the

indigent. We would rather today, and I think I voice the sentiment of you members, voluntarily give to the poor families our service, and more service, and receive their grateful thanks than to have the State say—"We will pay you 5 cents for a dollar's worth", and then have the people say—"You give that to us by right."

Therefore, I say that this proposition of the Relief Administration in ordinary times would probably not be acceptable to us, and yet we now are compelled to say that the argument for the relief of the doctors is rational.

Out of whose pockets is this salary to be paid? I can say for Essex County there are too many doctors whose income has been cut 50%.

If Dr. Reik has been here 10 years and done excellent work, he was engaged at his present salary when the scale of everything was very different from now, and he has been paid continuously all these 10 years, and last year when he had an opportunity to voluntarily take a cut commensurate with everything else, he declined. If the presidents of railroads are now being forced by the government to take $17,500 so as to have their institutions get any relief from the Reconstruction Finance Corporation, when they used to get $75,000 and $100,000 salaries, it seems a very small thing for us to talk about a cut under the circumstances. Furthermore, don't forget that much of Dr. Reik's work has been tremendously helped, not only by his own secretaries, but by the Field Secretary taking a tremendous amount of time and labor off his hands.

This Majority Report has been well considered. The Trustees have well considered the whole matter. There is no loss of appreciation of Dr. Reik, his age, his service, his ability, our Journal, but this Majority Report is the expression of the majority of this Society and it should carry.

Dr. Thomas P. Prout (Union County): I, perhaps, shouldn't say anything tonight, but I must because I am thinking back to the time when the Journal began. I go back to the time when I first began as an advertiser in the Journal, and I know what such advertising in the Journal meant then. If this means the return of the Journal to the status of the Journal of 1920, I am opposed to it, as an advertiser. I know that my advertisement in the Journal now means something. I can't say the same thing for the advertisements in the Journal of 1920. I know that the Journal is read now, and read through by a great many members of the Society; whereas in 1920, and until Dr. Reik became the Editor, I had no assurance that anything happened to it except that it went into the wastebasket.

If this means the destruction of the present character of the Journal, and that is the way I am inclined to interpret this matter, I am very much opposed to it and I think we are taking a wrong step in going at this matter in this way. It seems to me that the position of Editor of a medical journal of the peculiar characteristics of a State Medical Society Journal is sufficiently unique so that we ought not to consider questions of advance or reduction of salary; but rather, the question that should occupy our minds, is this: Can that man as Editor deliver the goods?

It makes all the difference in the world whether the Journal of the Medical Society of New Jersey has character or hasn't character. At the present time, it has a fine character as a Medical Journal, and that I know. I hope we do nothing to destroy it.

The question was called for.

President Lippincott: Dr. Cosgrove is recognized.

Dr. Samuel A. Cosgrove (Hudson County): If one-tenth of the appreciation that 2 of the Fellows of the Society, and the Secretary of the Society, have expressed tonight be true, this Society owes Dr. Reik a debt of gratitude far above what it has paid him in the past or may pay him now. You risk losing him, and you repudiate that gratitude for a comparatively small sum of money, which you immediately turn around and make a present of to the President, without any limit on his discretion as to its expenditure, for an entirely hypothetical need. If the Society has a membership of 2900, as the reader of this report has estimated, it means that you are selling your gratitude to Dr. Reik for about 70 cents apiece.

Now, I have suffered a 20% cut in my salary. God only knows what week it will be 100%. I could replace my Office Nurse, who has served me faithfully for several years, at a salary less than I am paying her, but I am not reducing her salary. And, it is just too damned bad if this august body has to treat a valued servant, who is contributing tremendously to its prestige and welfare, worse than anyone of us would treat one of his own employed staff.

Dr. Joseph F. Londrigan (Hudson County): I want to substantiate the remarks made by Dr. Mulford and Dr. Hagerty and Dr. Morrison. I wonder if the people who are

using this for an economic measure really mean it. I have been a member of the Welfare Committee for 10 years. The expenses of the Committee have been $750 a year during the past 7 years, or since Dr. Reik has been its Secretary. Why, it should be increased now, so that $2000 may be placed at the disposal of the President—not the Committee—I do not know.

At a meeting of the Hudson County Delegates last Friday, members of a neighboring County came to us and suggested that this Society buy a Permanent Home and spend about $20,000 for it, and the same people here today are trying to take away from us the best Secretary in the United States. I am certainly opposed to it, and so is Hudson County.

Dr. B. T. D. Schwarz (Hudson County): I am certainly very much surprised to hear the preceding speakers from Hudson County taking the stand that they did, because Hudson County, throughout all its meetings in the past year, has indicated very strongly that it wanted this reduction. The previous speaker wanted to know how real the question of economy is, in this case. I sometimes wonder too, because those gentlemen, on the floor of the Hudson County Medical Society, have been the most persistent advocates of retrenchment and reduction of expenses. This whole proposition seems to be not a question of reduction but one of leveling off the salary to the present status—what we all find ourselves in. Nobody's income is the same today as it was 5 or 6 years ago. I don't believe it is fair to characterize this as a reduction when it is merely leveling up the salary to the present day conditions.

Dr. E. Zeh. Hawkes (Essex County): I want to say a few words as a Delegate from Essex. Personally, I have the greatest respect for Dr. Reik. I have respect for his ability. I don't believe that anybody here is questioning that. But in our County there is a feeling that he is overpaid proportional to the rest of the doctors. He may be worth twice what we pay him, but if we can't afford to pay him, then we are paying him too much.

This State Society ran a deficit of $5000 last year. If we continued the same way, where will the deficit come from at the end of this year? The Essex County delegation has been instructed to come here and cast its vote for a reduction in salary. We weren't instructed to come here and criticize Dr. Reik; we have no criticism. We are instructed to come and ask him to take what we have all taken—a very substantial cut in income.

The suggestion is made that we will lose his services. If that suggestion has truth in it, then that removes from our consideration entirely all thought of sympathy for Dr. Reik which some have suggested. We can consider him and his salary entirely apart from any personalities or apart from any feeling of sympathy and purely on the basis of what is right in comparison with the rest of us. We take our cuts, we ask him to take his. That is the whole matter. It is not a matter of dissatisfaction, except the dissatisfaction of comparison.

Dr. E. G. Waters (Hudson County): A few remarks were made here to which I can't completely subscibe as a member of Hudson County's delegation. One is, that the Hudson County Society has gone on record unreservedly, as being opposed to any form of unusual or excessive expenditures. Hudson County has been always willing to pay for value received, and I think that this would probably hold in the case of Dr. Reik. Hudson County, however, has refused on its floor to permit certain of its own members to allocate to themselves the privilege of spending money on their own hook and without proper authorization, which steps have been properly curbed within our own bounds and borders.

I happen to have known Dr. Reik for some time and have a deep appreciation not only of his abilities but of his intense personal interest in the State Society itself. I think it is needless for me to stress further any of the remarks made by Dr. Morrison and some of the others who have given you a true picture of Dr. Reik's work.

Dr. Samuel Alexander (Bergen County): I have a great deal of respect for Dr. Reik's ability as a physician, a great deal of respect for the Journal of which he is the Editor, but that is not the point. There is a great principle involved in this thing, I think, and we know that business has been cut anywhere from 20 to 50%; we know that governmental employees have been cut anywhere from 20 to 40%; we know that the physicians of our State, I know the physicians of Bergen have been cut anywhere from 20 to 75%. I say, is it fair that those whom we pay should do as everybody else has done, take the cut just as everybody else has taken it? That is all I have to say.

President Lippincott: Any other remarks?

Dr. R. M. A. Davis (Salem County): There is only one point in this argument. If

Dr. Reik was worth the salary he began with some 10 years ago, with the rise in salaries during the 5 years or more up to 1929, he should have had during that time a raise in his salary of $2000 or $3000. Now, if he was worth it, as I said, 9 or 10 years ago, why should it be reduced when we are now back on the same plane we were 9 or 10 years ago.

Dr. Ralph K. Hollinshed (Gloucester County): There is just one phase of this matter which hasn't been brought out here tonight which I think it might be well to speak about, and that is—the fact that in this time of economic depression, and in the time when we are threatened with socialized medicine, we need the services of Dr. Reik more even than we ever did before. We need his leadership, we need his guidance and he has proved that he has a thorough understanding of these economic problems which confront us at this time. Now, can we afford, particularly now, to lose his guiding spirit?

President Lippincott: I am going to put the question.

Member: I move an amendment to the report. I move the contingency——

Secretary Morrison: You can't move an amendment to the report of the Budget Committee. It must either be approved or disapproved.

President Lippincott: Are you ready for the question?

The motion was put to a vote and there was division.

President Lippincott: Those in favor, will please rise. (62 arose).

Cries of "Roll Call" from the audience.

Secretary Morrison: All right, a roll call. We have a list of Delegates.

Member: I rise to a point of order. Nobody in the House has a right to demand a roll call until the motion is put, a vote for the "ayes" and "nays".

President Lippincott: I will call for the negative vote. (45 arose).

The motion is carried.

Dr. Richard M. A. Davis (Salem County): I ask for a roll call.

President Lippincott: Report of the Committee on Workmen's Compensation Law. Is there anyone representing that Committee present? (No response)

Report of the Committee on Investigation of "State Medicine". (No response)

Is there any unfinished business?

Secretary Morrison: None, Mr. President.

President Lippincott: New business.

Dr. E. Reissman (Essex County): In view of the small delegation that is usually here the last day of the session, I would like to offer a resolution that the last meeting of the House of Delegates be held on Wednesday or Thursday, instead of Friday.

The motion was seconded.

President Lippincott: Are you ready for the question?

The motion was put to a vote and carried.

Dr. Reissman: I will make it definitely on Wednesday.

President Lippincott: I will put the question again—for Wednesday, June 7.

The motion was put to a vote and carried.

President Lippincott: May we now have the Report of the Board of Trustees, Dr. Nafey?

Report of the Board of Trustees

To the President and the House of Delegates of the New Jersey State Medical Society: During the past year, the Board of Trustees has held 4 meetings for the transaction of the Society's business. The work of the Board this year has been conducted under the plan set up the preceding year by which it has been made possible to maintain contact with the various committees and agencies of the Society as a whole.

The plan is to make the Society and all its activities revolve around the President during the year of his presidency; to familiarize the incoming Presidents with certain branches of the Society; and, as well, to have the Chairmen of important committees know what the Board of Trustees are doing; and to have the Executive Secretary's office and its activities report to the Board through the President of the Society. Under this plan, also it has been the practice this year to have present at the meetings the Chairman of the Finance Committee, the Chairman of the Publication Committee, the Chairman of the Program and Arrangements Committee, the Chairman of the Committee on Medical Education and Hospital Activities.

The plan has made it possible for the Board to follow the work of its various committees throughout the year and by the reports submitted act intelligently in the matters pertaining to the welfare of the Society as a whole.

Conditions through the State pertaining to relations between lay Hospital Boards and Hospital Medical Staffs have been mentioned in the President's report at the Annual Meeting. The action taken in this matter was the result of certain transactions in one of the Newark Hospitals. The following resolution was adopted:

"That the Committee on Hospitals and

Medical Education be requested to consider the advisability and feasibility of establishing definite requirements and standards, to apply in the relationship of members of the Society to the Public and Quasi-Public Hospitals, Clinics and Dispensaries; and that the Committee, if it deems it expedient, be requested to formulate such standards."

Three members of the Board of Trustees were appointed as a Committee to sit with the Committee on Hospitals and Medical Education, as a joint Committee, for action on this matter. The action of the joint committee has been published in the State Journal.

During the year it has become apparent that definite opposition had developed in the County Societies to the plan of the State Society to Control Specialism in the State. A communication was received from the Secretary of the Hudson County Society, apprizing the Board of Trustees of the strong opposition in that County to the plan. The Board of Trustees, acting on the knowledge of the opposition to the plan, postponed any further action to put the plan into operation until the next meeting of the State Society, when the matter will again be brought before the House of Delegates.

In view of the present financial conditions throughout the country and reduced returns to the Society, the advisability of continuing the Scientific Exhibit at this year's Annual Meeting was carefully considered. It was decided its omission would not be advisable, in view of the high standard which had been made at our last meeting and the very favorable comments which had been received on the success of that exhibit.

Reports received from the Treasurer and Chairman of the Budget and Finance Committee at the several meetings during the year make it clear that in view of the diminished returns from various sources of revenue of the Society, it will become necessary during the coming year to curtail expenses and increase the membership assessment above the present fee of $10.

The Board of Trustees has taken into consideration the disadvantage of having the executive offices of the Society in the southern end of the State, in Atlantic City. In order to facilitate the work of this office and to coordinate it with the activities of the other State health agencies, as well as the legislative activities of the State, it is thought advisable to investigate the advisability of moving this office to Trenton. The latter is almost the geographic center of the State. A Committee has been appointed to go into this matter with the idea of acquiring such an office and also to investigate and report at a subsequent meeting on the establishing of a Permanent Home for the Society in quarters to be acquired by the Society as its own property, there to house the office of the Society, and establish a permanent place for Society records, library and committee meeting rooms, etc.

At a special meeting of the Board this evening, just preceding this meeting, the matter of salaries was taken up. Dr. Reik had submitted an additional plan or a plan to the Board of Trustees by which certain changes were recommended and certain economies could be effected. This suggestion was talked over and it was thought advisable to have Dr. Reik come before the meeting and talk to us about it and explain his position.

Dr. Reik did not leave that recommendation stand but withdrew it and made the declaration that he would not accept any change whatsoever except the conditions as they now stand.

A motion was made, seconded and carried, by the Board of Trustees that the Board of Trustees shall reduce salaries for the next fiscal year: the Editor of the Journal and Executive Secretary, 20%; the Field Secretary, 15%; and the Office Secretary, 10%.

Respectfully submitted by,

H. W. Nafey, M.D., Secretary.

President Lippincott: You have heard the report.

Dr. Cosgrove: I would like to correct a portion of the report as you have just heard it. Dr. Nafey said that the report of the subcommittee of the Committee on Hospitals and Education had not been completed and was still in Committee. I would like to correct that statement, if you please. At a meeting of the Committee on Hospitals and Medical Education, held at the Stacy-Trent Hotel in Trenton, April 9, 1933, the sub-committee made its report, as printed in the Pre-Sessional Report of that Committee in the May Journal and upon motion regularly seconded and carried, the whole Committee adopted that report, as exhibited in the minutes of the Committee.

Subsequently, at the instruction of the Committee, the Chairman appeared before the Board of Trustees and the action of the Committee in revising the Sub-Committee's Report was communicated by the Chairman at the meeting of the Board of Trustees the same date, and it was the sense of that body that inasmuch as a large portion thereof required

deliberate study, the Board of Trustees would receive the *pre-report* as a progress report, instructing the Committee to have copies of the revised recommendations struck off and distributed to each member of the Board of Trustees to be acted upon by that body at its meeting on the eve of the Annual Convention of the Society in June. Copies were struck off and mailed to each member of the Board of Trustees in accordance with that instruction and in that fashion, and the whole matter passed from the hands of the Committee on Hospitals and Medical Education directly to the Trustees for further action and recommendation to this Society.

Dr. Nafey: Mr. President, may I say I should have corrected that to read—"It remains in the hands of the Board of Trustees". The Board of Trustees has not taken further action on your report, and our meeting was not held last night, but it was held this morning and no action was taken on that matter. I should have said the "Board of Trustees" instead of the "Committee."

President Lippincott: We will accept that. Are you ready for the question? All in favor will signify by saying, "Aye." Contrary, "No." It is so ordered.

Report of the Committee on Honorary Membership, Dr. Mulford.

Dr. Ephraim R. Mulford: I haven't the report. Dr. Harvey was to make the return. I haven't the report of this Committee.

Secretary Morrison: Has the Committee any action to recommend?

Dr. Mulford: Yes, there were names submitted but I haven't the list of names.

Secretary Morrison: Can you get them from him so we can act on them before the last meeting Wednesday adjourns?

Dr. Thomas W. Harvey, Jr.: Dr. Harvey sent a report to Dr. Reik, I believe.

President Lippincott: Any unfinished business? Any new business?

Dr. W. Blair Stewart (Atlantic County): Under the head of "new business", you have just adopted, I believe, that the last meeting of the House of Delegates shall be on Wednesday. The Constitution and By-Laws calls for the *election of officers* to come on the second day of the meeting and that meeting is scheduled for 2 p. m. tomorrow afternoon, for the election of officers only. As Chairman of the Committee that arranged this program, I submit that your entire morning tomorrow and Thursday, will be filled with the Section meetings. If you hold your meeting in the morning, you are going to upset the entire program and you are going to take members away from the Section meetings or from the House of Delegates.

Our good President here has arranged a program that will take the entire afternoon, an excellent program, and if you meet in the afternoon, you are going to cut in on his program and you are not going to accomplish what we intended to accomplish from a scientific standpoint nor from a business standpoint. Your entire evening is filled with out-of-town guests who have been asked here to address you on an important subject. When are you going to hold the meeting? I am not sure whether the Constitution and By-Laws calls for a final meeting on the last day; my impression is (if Dr. Quigley is here, he can answer it) it does call for a meeting on the last day, which is Friday, and has been provided for on Friday afternoon. I think that this House had better reconsider the motion that was passed here—for a meeting of the House of Delegates to be held tomorrow—unless you can squeeze in time in the early hours of the morning, before the program that has been arranged.

Dr. Reissman (Essex County): Mr. Chairman, there is a meeting tomorrow afternoon, at 2 o'clock, of the House of Delegates. Whatever business is left over, I think could be settled at that time (I don't think it will take up so much of our time), rather than to have a very small meeting with small attendance on Friday. I think we can do better business with a good substantial membership.

Secretary Morrison: Why not have it Wednesday or Thursday afternoon, after the close of the Scientific Session, about 5 o'clock?

Dr. Reissman: Well, if they will accept the amendment.

Question: Wasn't that motion passed for the future, not for this year?

Secretary Morrison: No, it was for this year.

Dr. Ralph K. Hollinshed (Gloucester County): Mr. President, as a member of the Committee on Scientific Program, I would like to register my protest against disrupting the Scientific Programs of this Society. I have served as Chairman of the Scientific Program for several years and I know the tremendous amount of work Dr. Stewart has done to get these men to come here and read papers. I think it is just too bad if the regular order of business is again upset in this way. I feel that it is an imposition on the Committee in charge, and it is not fair to the Society to break up the Scientific Program.

The meeting tomorrow afternoon of the House of Delegates is for "election of officers

only" and has been specifically stated in the program. I think this program has been worked out and it is a credit to the Chairman of the Committee, and I think it should be gone through as scheduled.

Dr. Quigley: Mr. President, I think Dr. Hollinshed's protest is well founded. There isn't any need of upsetting the program. The House of Delegates, however, has the right to adjourn from time to time and set its time, providing it doesn't interfere with the Scientific Session. So, if we were to meet, as Dr. Morrison suggested, Wednesday immediately at the close of the Scientific Session, it will interfere with nothing.

Secretary Morrison: Mr. President, I move we reconsider the vote previously taken on this proposition.

The motion was seconded by Dr. W. Blair Stewart, put to a vote and carried.

Secretary Morrison: Now, Mr. President, I move the final session of the House of Delegates this year be held Wednesday at 5.30 p. m.

The motion was seconded, put to a vote and carried.

Secretary Morrison: Mr. President, I have 2 resolutions I would like to introduce.

Amendment to Dr. Quigley's Resolution

(1) "When any member of a Hospital Staff, or the entire Staff has been dismissed because of their defense of proper principles, without a hearing, no member of the State Society shall offer to fill his place or their places on the Staff without incurring the possibility of expulsion from the Medical Society of New Jersey, until the matter has been investigated at a meeting of the Judicial Council, to which the members of the Staff, the President and Secretary of the County Society in which the Hospital is located, and the members of the Board of Trustees have been invited, in writing."

I offer this resolution and move its adoption.

The motion was put to a vote and carried.

Secretary Morrison: I have another resolution.

During the past 2 years it has been my privilege to serve as President of the Essex County Tuberculosis League. I have become very familiar, indeed, with the great lack of sanatorium accommodations in the State of New Jersey. We take in *incipients*, treat them for 6-12 months, until they have reached a stage of *arrest* in pulmonary tuberculosis, where hospitalization can no longer be of benefit. But, we have no place to put them. They are not ready to go home, and the State has not provided any buildings in which we can accommodate them. The consequence is that they are occupying beds for months and months, sometimes 6 months or longer, at the expense of *incipients* who are on the waiting list for weeks and weeks. In the larger counties that waiting list amounts to 100, and these poor patients, in the incipient stage of tuberculosis, when something could be done for them, must wait for proper hospitalization, and until their disease often has reached the stage where they are no longer amenable to cure.

(2) Therefore, I offer the following:

Resolution to Appoint Committee to Secure Funds from the R. F. C. for Hospital Purposes

"Resolved, that the Chair appoint a committee of 3 to confer with Commissioner Ellis of the Department of Institutions and Agencies, and also with Governor Moore, in an attempt to secure from the funds of the R. F. C. such moneys to increase the sanatorium capacity of New Jersey and to provide for the erection of a preventorium in northern New Jersey."

The resolution was seconded, put to a vote, and there was a division. The resolution was re-read.

Dr. Theodore Teimer (Essex County): While we may be in favor of a resolution of this kind, or may be against it, I think it is manifestly not our province to tell the Governor where he shall get the money. We can't tell the Governor he can go to the R. F. C. I think it is an assumption of power that we do not possess. The Governor may use his judgment. We can't prescribe.

President Lippincott: Are you ready for the question?

The motion was put to a vote and lost.

President Lippincott: Is there any new business?

It was regularly moved, seconded and carried, that the meeting adjourn, which it did at 11.20 p. m.

Wednesday Afternoon Session

June 7, 1933

The third session of the House of Delegates of the Medical Society of New Jersey convened at 2 o'clock, with Dr. A. Haines Lippincott, President, in the chair.

President Lippincott: This session is for the Election of Officers. I call for the Report of the Nominating Committee by Dr. Hagerty.

Report of the Nominating Committee

Mr. President, at the regular meeting of the Nominating Committee held at Atlantic City, June 6, 1933, the following nominations were made, to be presented to the House of Delegates, and they are herewith submitted.

President, Frederic J. Quigley; President-Elect, Lancelot Ely; First Vice-President, Marcus W. Newcomb; Second Vice-President, Francis R. Haussling; Secretary, J. Bennett Morrison; Treasurer, E. J. Marsh.

Trustees: First District, Charles B. Smith; Third District, Harry R. North; Fourth District, William G. Herrman; Fifth District, Walt P. Conaway.

Judicial Council: Fourth District, James Fisher.

Member of Committee on Scientific Work, W. Blair Stewart.

Delegates to the American Medical Association, A. H. Lippincott and E. R. Mulford.

Alternate Delegates to the American Medical Association, Stephen Quinn and S. B. English.

Committee on Publication, Henry C. Barkhorn.

Committee on Program and Arrangements, Wm. D. Olmstead, John W. Gray (for the unexpired term of M. W. Reddan).

Committee on Honorary Membership, W. E. Darnall (to replace W. G. Schauffler), E. R. Mulford.

Respectfully submitted,

(Signed) John F. Hagerty,
Chairman, Nominating Committee.

President Lippincott: Gentlemen, what is your pleasure with this report?

It was regularly moved, seconded and carried that the nominations be closed and the Secretary instructed to cast a ballot for all those named.

President Lippincott: The ballot has been cast and I declare these gentlemen elected to the various offices.

It gives me great pleasure at this time to introduce to you your new President, Dr. Quigley!

President-elect Quigley: Mr. President and Members of the Society: I am entirely sensible of the great honor that has been conferred on me. I am elated. That elation is understandable, I think, and justifiable. However, that feeling of elation is subdued, I might say almost submerged, by the knowledge of the responsibility that this office entails.

There is on our program no place for an Address of the Incoming President. With a change in the By-Laws, I hope, personally, that in the future there will be an opportunity for such an address because the policies of the Incoming President are of equal importance to the Society as is the experience of the Retiring-President.

I have the spirit and will to be of service. With your help, I trust that I may prove to be a good President. To you all, I wish to say again that I appreciate more than I can express, the confidence you have displayed in me by this election.

President Lippincott then introduced the other newly elected officers that were present.

President Lippincott: We will recess now until time for the General Session.

The meeting adjourned at 2.25 p. m.

Wednesday Afternoon Session

June 7, 1933

The fourth session of the House of Delegates convened at 6 o'clock, President Lippincott presiding.

President Lippincott: The meeting will please come to order. We will now receive the final Report of the Board of Trustees, by Dr. Nafey.

Final Report of the Board of Trustees

Dr. Herbert W. Nafey: At a special meeting of the Board of Trustees held this morning, the Report of the Joint Committee on Hospitals and Medical Education, with that of the Committee from the Board of Trustees, which has been received, was taken up for action. The Board wishes to commend the Joint Committee on the general excellence of its report. There are parts, however, which, in the opinion of the Board, require re-consideration and some changes. It was resolved, therefore, to refer the Report back to the Joint Committee for further study and correction, and after re-submission of the corrected report to this Board for approval, the recommendations contained therein shall become effective.

Acting upon the Report of the Budget and Finance Committee, the matter of the per capita assessment for the coming year was decided upon and fixed at $13 per member per year.

Respectfully submitted by,

H. W. Nafey, M.D.,
Secretary.

President Lippincott: What is your wish with regard to this report?

It was regularly moved, seconded and carried that the Report be received and filed.

President Lippincott: The next item on the program is the determination of the meeting place for next year. Does anybody have any suggestions?

Dr. Marcus W. Newcomb: Isn't that taken up by the Nominating Committee?

Secretary Morrison: No, it is not the function of the Nominating Committee any more.

Dr. Newcomb: I move we meet in Atlantic City in 1934.

The motion was seconded, put to a vote and carried.

President Lippincott: Report of the Business Committee, Dr. Stewart.

Report of the Business Committee

Mr. Chairman, there have been 3 minor points that have been referred to the Business Committee, and I will just briefly refer to them.

(1) In Dr. Morrison's report, he spoke about the 2000 medical students abroad, and their coming back to this country and trying to enter into the practice of medicine, and the trouble that they have been having and will have with the State Boards and with the National Boards. It seems that this matter has been thrashed out pretty thoroughly by the American Medical Association, and your Committee reports that in regard to the status of the medical graduates of foreign universities, the Committee refers to the decision of the Council on Medical Education and Licensure of the American Medical Association, which states that license to practice must first be secured in the country in which the medical education is attained.

(2) Referring to the question of those members of the Society, the Associate Members, who do not pay any dues and who are not entitled to the Journal and the other perquisites of the New Jersey State Medical Society, the Committee recommends that the term—*Associate Members*—be applied to the younger members of the profession who have residence in the counties and privilege of membership for a limited time without payment of dues, and physicians living in adjoining counties who have been listed as *Associate Members* shall be known as *Non-Member Associates*.

I don't know why the House of Delegates wished upon the Business Committee a decision upon the question of medico-economic care in this country, and expected us to decide this whole question as between a Majority and a Minority Report within a period of less than 4-5 hours of time.

Your Committee has been unable to make a definite decision, and we, the members of that Committee, refuse to put ourselves on record as favoring either one or the other. We have our own ideas in regard to some points in both, but, our report as given with regard to the Majority and the Minority Reports on the Report of the Committee on the Costs of Medical Care, is this: Your Committee finds it impossible, because of insufficient time, to render any definite conclusion, and recommends only publication of such reports in the Journal, in line with the information which the Editor has been supplying, for the study of all members of the Society, and a possible report by the Committee at a later date.

W. Blair Stewart,
R. M. A. Davis,
John F. Hagerty.

President Lippincott: You have heard the report of the Business Committee. What is your wish?

Dr. B. S. Pollak (Hudson County): This is a subject that has concerned a good many committees for a long, long time. I know that in our County, a committee of 15 were busy with the study of that Report for 6-7 weeks and it consumed a very great amount of study and consideration. It seems to me, Mr. President, this subject is of sufficient moment to be placed in charge of either the Business Committee or some Special Committee that shall go into the details of the Report exhaustively, and make a decision and report to the Board of Trustees; not that it should be published without consideration but that it should be thoroughly studied either by the Board of Trustees or a committee appointed by the incoming administration, to that effect. As we all know, this is of tremendous importance to all the practitioners of the State and ought to receive considerable thought and discussion.

President Lippincott: Dr. Pollak, I think this Report should be received, and then will you make a motion to that effect? Don't you think that would be the proper way?

Dr. Pollak: I move that we receive the Report of the Business Committee.

The motion was seconded, put to a vote and carried.

Dr. Pollak: I move, Mr. President, that the Report of the Business Committee relative to the Majority and the Minority Reports which have been submitted by a Sub-Committee of the Welfare Committee, be submitted to this

Committee, or to some other committee appointed by the incoming administration, for the purpose of going into this subject exhaustively and reporting to the Board of Trustees, and subsequently to the membership of the State Society.

The motion was seconded, put to a vote and carried.

President Lippincott: The other recommendations were about the *Associate Members* and *Non-Member Associates*. Dr. Stewart, have you any resolutions, or any motions, to make in reference to that?

Dr. W. Blair Stewart: We had no resolution, except we recommend the term, as given by Dr. Morrison, for those *Non-Member Associates*.

Dr. Quigley: I didn't quite get that. Did you say Non-Resident Members?

Secretary Morrison: Dr. Quigley, since we adopted the amendment to the Constitution providing for Associate Members, there can only be 1 class of Associate Members, and that class must be the Junior Members, who are accepted for a year on probation. All the County Societies have for years carried a list of Associate Members, some of them living in the State, and some living outside of the State. We are providing a new name for that class of membership.

President Lippincott: Is Dr. Stewart's motion seconded?

The motion was seconded, put to a vote and carried.

Dr. W. Blair Stewart: There was no other recommendation. The matters referred to us by Dr. Reik's report require no action on the part of our Committee.

President Lippincott: A motion to adopt the Report of the Business Committee, please.

Dr. Pollak: I move its adoption.

The motion was seconded, put to a vote and carried.

President Lippincott: Committee on Honorary Membership.

Secretary Morrison: Mr. President, I have the following Report from Dr. Thomas W. Harvey, Sr.

Report of Committee on Honorary Membership

"We recommend to the House of Delegates the nomination of Dr. John B. Pellet, of Hamburg, New Jersey, to Honorary Membership in the Medical Society of New Jersey."

Dr. Pellet, you will recall, is an ophthalmologist who has lived in the northern part of the State all his life and practiced in the village of Hamburg, and I heard Dr. Kipp say once that he had an international reputation.

It is to this gentleman, 87 years of age, with 61 years in the practice of medicine, to whom we wish to extend the Honorary Membership Degree.

President Lippincott: I so declare this done. I will now call for the Report of the Committee on the Art and Hobby Exhibition, Dr. Campbell, Chairman.

Report of Art and Hobby Exhibit

1933 Annual Meeting

Medical Society of the State of New Jersey

I am herewith handing the Executive Secretary my Report as Chairman of the Art and Hobby Exhibit, held June 7 and 8, 1933, at Haddon Hall, Atlantic City.

Dr. Henry O. Reik had suggested the holding of such an exhibit a number of times during the past few years, and on January 19, 1933, wrote me asking if I would accept the Chairmanship of such a Committee; stating that the President, Dr. A. Haines Lippincott, and he, had a conference during the previous week and that Dr. Lippincott had approved the holding of such an exhibition.

On March 10, Dr. Lippincott appointed the Art and Hobby Exhibit Committee as follows: Dr. William K. Campbell, Chairman; Drs. Henry B. Orton, Solomon S. Bauch, M. J. Kauffman of Newark, C. D. Martinetti of Orange, Lancelot Ely of Somerville, F. J. Hughes and H. F. Johnson of Plainfield, Mrs. A. Haines Lippincott of Camden, Mrs. R. A. Shirrefs, Mrs. Norton A. Wilson and Dr. Milton A. Shangle of Elizabeth.

On March 17 a letter was sent by the Chairman to each member of the Committee, notifying them of their appointment and asking them to give thought to the plan and to suggest time and place to hold a meeting.

A meeting was called at 3 p. m. April 18 at the Academy of Medicine of Northern New Jersey, at which time were present: Dr. Lancelot Ely, Dr. F. J. Hughes, Dr. H. B. Orton, Dr. H. F. Johnson, Dr. M. J. Kauffman, Dr. C. D. Martinetti, Dr Henry O. Reik, Dr. W. K. Campbell. At this meeting it was decided to hold an exhibit to cover (1) Art—Painting, Sculpture, Etching, Modelling, Needlework, etc. (2) Photography—Movies, Still, Color. (3) Hobbies—(a) Collections, (b) Trophies. It was decided to limit the exhibit to the members of the State Medical Society, the Woman's Auxiliary, and their families. Proper entry blanks were decided upon, such business arrangements as were necessary were made, the Woman's Auxiliary of Atlantic City was asked to act as receiving committee and hostesses. It was decided to have any further meetings at the call of the Chairman.

Immediately thereafter with the coöperation of the Executive Secretary, Dr. Reik, the entry blanks were printed and the Chairman forwarded to the Secretary of each County Medical Society and to the Secretary of each County Woman's Auxiliary, a number of blanks, together with a letter explaining the proposed exhibition and urging coöperation.

The Committee met Dr. Lippincott and Dr. Reik at Haddon Hall on May 28 to complete final arrangements and on Tuesday, June 6, the Committee met in the Exhibition Room at 11 a. m., where Drs. Hughes, Johnson, Kauffman, and Mrs. A. Haines Lippincott and Mrs. Blair Stewart with Dr.

Emery Bokor, who had been added by the Chairman, acted as a Hanging Committee to place the exhibits.

Exhibits were made by:

Mary Lea Davis	Bonnie Babcock
H. L. Lockwood, M.D.	B. Tait McKenzie, M.D.
Francis Smith Johnson	Walter B. Mount, M.D.
Chevalier Jackson, M.D.	Mrs. Henry O. Reik
Mrs. Blair Stewart	J. Corwin Mabey, M.D.
C. Garrabrant, M.D.	William L. Vroom, M.D.
Emery Bokor, M.D.	Leopold Goldstein, M.D.
Harold F. Johnson, M.D.	M. J. Kauffman, M.D.
Edgar Burke, M.D.	Lancelot Ely, M.D.
Frederick J. Hughes,M.D.	Dr. & Mrs. G. S. Laird
Donald B. Hull, M.D.	Mrs Thos. P. McConaghy
John F. Hagerty. M.D.	Mrs. George L. Orton
Marshall Smith, M.D.	Russell Seymour, M.D.
David L. Farley, M.D.	Master Bob Salasin
Jane Babcock	Wm. K. Campbell, M.D.
Catherine Babcock	

The exhibits aroused a considerable amount of interest, and many of the members and their families visited it. On Thursday afternoon, Dr. Emery Bokor gave a talk on Art, which was very interesting.

As a number of the exhibitors wished to remove their exhibits on Friday morning it was decided by the Committee to close the exhibit Thursday night.

The Chairman wishes to express his appreciation for the efforts of the members of the Committee, and for the time they spent, and especially those who acted on the Hanging Committee, and who made the exhibit a distinct success.

The outstanding exhibit was probably Dr. R. Tait McKenzie's bronze plaque entitled "Joy of Effort". Of the paintings, I think it was generally conceded that Dr. Frederick J. Hughes' "Early Spring at Chimney Rock", and "Tennis Player" and "Still Life" were outstanding in composition and execution. Dr. Harold F. Johnson's paintings, particularly "Russian Doll" and "Our Children" with Francis Smith Johnson's paintings, elicited much favorable comment.

Dr. Edgar Burke's paintings of bird life were exceedingly beautiful and admired by everybody. Dr. Emery Bokor's "Story of the Apple" created much interest and speculation. Dr. David L. Farley's plaque and Dr. Emery Bokor's linoleum carving were very much admired. Dr. Marshall Smith's bronzes and jewel box were examples of very beautiful sculpture and cabinet work.

Mrs. Blair Stewart's old family quilts, parts of an old trousseau, and a very old carriage parasol caused particular interest among the younger visitors. Dr. J. F. Hagerty exhibited from his collection of etchings several that were outstanding and added much to the exhibit.

Dr. Chevalier Jackson, of Philadelphia, exhibited a very beautiful small painting entitled "A Landscape". Dr. H. L. Lockwood exhibited 2 paintings, "Metedaconk" and "Passaic in Autumn". Dr. C. Garrabrant exhibited an old family Bible with its original wooden covers and hand wrought iron hinges. Also an old scarifier and an old picture of Dr. Jonathan Pittman, the founder of Atlantic City.

Mary Lea Davis' "King Arthur's England", her models and 2 posters showed a considerable artistic ability. Dr. Donald B. Hull exhibited 2 paintings, "Boat" and "Still Life". Dr. M. J. Kauffman's figurines made of Russian bread and the story of their making were not only exceedingly interesting but evidenced the latent artistic ability that is undoubtedly in the make-up of many a physician. Dr. Leopold Goldstein exhibited 3 crayon drawings of pathological specimens. Dr. Walter B. Mount had a very interesting collection of obstetrical stethoscopes.

Mrs. George Orton's hand-made linen bedspreads and Mrs. Thomas P. McConaghy's china painting were not only highly artistic but evidenced great ability. Dr. Lancelot Ely's collection of Indian stone implements, silver jewelry and pottery were evidence of a well grounded interest and knowledge of Indian life and activity in the Southwest. Dr. and Mrs. G. S. Laird exhibited some very beautiful jewelry which it is their hobby to make themselves, and which showed a high grade of artistic ability as well as meticulous care in the details of making.

In the exhibit of photographs the outstanding feature was Dr. J. Corwin Mabey's photographs. Dr. Mabey sent 30, but due to lack of room it was only possible to hang 18 of these, the Committee having considerable difficulty in choosing, as it seemed that they were all so wonderfully good it was difficult to select one and leave out another. Mrs. Henry Reik exhibited 5 groups of photographs which were very beautiful and showed a high sense of composition and artistic value with good photographic technic. Dr. W. L. Vroom exhibited some very beautiful photographs made at and about Lake Louise, Canada.

The children certainly also showed artistic ability. Jane, Catherine and Bonnie Babcock, aged 12, 11, and 8, with their models drew a great deal of attention and interest. Dr. Russell Seymour's son's 2 boat models and Master Bob Salasin's aeroplane models certainly stood high in the estimation of everyone who saw them.

The exhibition evidently also attracted lay attention, as representatives of the press came several times. Several papers, especially the Philadelphia Ledger and the New York Times, wrote it up, with much favorable comment, the latter, especially, giving it a large 2-column headline in the Sunday Edition.

Wm. K. Campbell,
Chairman, Art & Hobby Exhibit.

Secretary Morrison: Mr. President, before we adjourn, there is just another matter I would like to refer to for clearing up some little doubt. The Essex County delegation has been accused by the Delegates of some of the other Counties, of attempting to "ring in more Delegates" at the meeting yesterday than they were entitled to have. This is a false accusation, and I want to explain it. They came down here with a large delegation. They were entitled to 1 more delegate who could not come and they had no other Alternate Delegate here to put in his place, i. e. no elected Alternate Delegate. So, the President of the Essex County Medical Society appointed another man, a member of the County Society, as a Delegate. He did this unknowingly. He didn't know that the Constitution provides that the Delegates and Alternate Delegates must be elected by the County Society. He should have been so advised by his informers.

I would have allowed the selection to go so far as I was concerned, but another member

of the Essex County delegation came to me, in reference to the Nominating Committee, and said, "Here, Morrison, you are accepting on the Nominating Committee a man who is not an *elected Delegate.*"

I said—"No, that is not so."

He said—"Yes, it is. The name of a man from Warren County is published in the program, and he is not an *elected Delegate.*"

I said: "That man is not serving on the Nominating Committee. We have searched him out and told him he cannot sit, and it so happens his Alternate Delegate, who is an *elected Delegate,* is present. So the Alternate Delegate was sent in to represent that County instead of the man whose name appears in the program."

Having been faced with the necessity of enforcing the Constitution in regard to the House of Delegates, it was necessary to enforce it in regard to the Nominating Committee; it was necessary to enforce it in this single instance in regard to both. That explains the situation.

President Lippincott: I hope the Delegates will accept the explanation of the Secretary.

Dr. Carrington: The total registration at 5.30 p. m. today was 678.

Dr. John H. Herman (Essex County): In one of the sessions of the House of Delegates yesterday the Report of the Public Health Committee was presented by Dr. Nichols and received. I would like to move that that Report be at this time *adopted.*

Dr. Quigley: I second the motion—that the recommendations be adopted.

The motion was put to a vote and carried.

Dr. William H. Areson (Essex County): Mr. President, I am President of Essex County Medical Society, and I am very glad to have had this explanation from Dr. Morrison. It was an error of judgment perhaps, an innocent mistake. It could easily have been misinterpreted. But we came down here *pretty nearly 100%* as a County this year. Today, Essex County *is 100% present.* We have 48 Delegates here today, *which is something.*

As Chairman of that delegation, I wish at this time to acknowledge my appreciation of the faithful attendance of the Delegates, their loyalty, and next year we will promise to come 100%, too. I thank you.

Dr. Quigley: Mr. President, I would like to present the amendments, which were proposed yesterday, for final reading. They are short.

Amend Chapter V, Section I, by deleting in the first and second lines of the last paragraph, following the word *at* and before the word *the,* the words "the close of the afternoon session on," and substitute "8.30 p. m." In other words, it makes the Nominating Committee meet at 8.30 p. m. on the evening of the first day of the Annual Meeting.

Mr. President, I move the adoption of this amendment to the By-Laws.

The motion was seconded by Dr. Pollak, put to a vote and carried.

Dr. Quigley: Amend Chapter VIII, Section 2, by adding immediately under the words "Hospital and Medical Education" the words "Committee on Medical Defense"; and immediately under these words "Committee on Insurance".

The purpose of that is to convert these 2 Special Committees into Standing Committees.

Mr. President, I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: Amend Chapter VIII by renumbering Sections "12, 13, 14, 15, 16" as "14, 15, 16, 17 and 18," respectively.

This is made necessary by the addition of these 2 Standing Committees which necessitated additional sections.

Mr. President, I move its adoption.

The motion was seconded, put to a vote and carried.

Dr. Quigley: Amend Chapter VIII by creating 2 new sections "12" and "13" as follows:

"Section 12. The Committee on Medical Defense shall consist of 5 members, appointed annually, and shall have charge of all matters pertaining to alleged malpractice of members. It shall maintain contact with the Judicial Council and refer questions of an ethical nature to that body."

I move its adoption, Mr. President.

The motion was seconded, put to a vote and carried.

Dr. Quigley: Section 13. The Committee on Insurance shall consist of 7 members, appointed annually. It shall arrange, with carriers, for various types of insurance, except professional liability, to be available to members, and covering particularly health, accident, life and automobile. It shall supervise the application of such insurance to members of the Society."

Dr. Quigley: I move its adoption, Mr. President.

The motion was seconded, put to a vote and carried.

President Lippincott: A motion for adjournment is in order.

Dr. Schlichter (Union County): Mr. Presi-

dent, word has come to us that the second committee substitute of Senate Bill 125 has unanimously passed the Senate and is now to go to the House of the Assembly. It was thought wise at first to call a meeting of the Welfare Committee but upon making a check-up we find not all members of the Welfare Committee are here. I am going to ask the House of Delegates if they think it wise to pass this resolution so we can send it on to the Assembly, and we believe it will have a wholesome effect, if anything will.

May I explain what Senate 125 originally was? It was a bill to take over certain allocated funds and pass them through the State Treasurer's office, giving the Legislature the power to give these funds to certain boards. Now the 11 professional boards, feeling that their income did not come from taxation but from candidates for licensure, were opposed to that and we in the Welfare Committee backed them up.

It was shown that in all States where the Legislature had the power to give these boards funds, very many of them went without. In some States, the profession itself is taxed in order to give the State Board of Health Examiners the money wherewith to prosecute offenders. In our State, as you all know, this money comes from the fees that are paid by the candidates.

In Senate 125, the second committee substitute, the Associated Boards had prepared an amendment which would have permitted the Boards to retain the money they received. This bill that was passed last night was passed without that amendment. We got in contact with the Senators, but it seems that it was probably a party or administration measure because it was passed unanimously despite the fact that certain Senators had promised us that they would vote against it.

The resolution I want to introduce as Chairman of the Welfare Committee is as follows:

Be it resolved, That this House of Delegates of the Medical Society of New Jersey, here assembled, protests the passage of the committee substitute Senate Bill 125 in its present form.

This resolution is to be sent to every Assemblyman in the State, and I would further urge that every member of the House of Delegates get in touch with his Assemblyman and ask him to vote against this bill in its present form. We are perfectly willing to accept it, if the amendment which was offered by the Conference of Professional Societies is included in the bill.

I move the adoption of the resolution.

The motion was seconded.

Dr. Quigley: Mr. President, might I ask Dr. Schlichter whether he thinks it might be well to include in that resolution that we are opposed to the bill in its present form unless an amendment exempting professional boards is adopted?

Dr. Schlichter: I think that would be wise.

President Lippincott: We will make that part of the main question.

Dr. Newcomb: Is it the consensus of the House of Delegates that we are to introduce an amendment to this bill exempting the boards?

Secretary Morrison: Professional boards.

Dr. Schlichter: Such an amendment was introduced in the Senate and voted down.

Dr. Newcomb: Are we to have an amendment in the Assembly?

Dr. Schlichter: That is my thought.

Dr. Newcomb: What is the instruction of the House of Delegates if we offer this amendment and we vote for the amendment and it is voted down? There are 3 medical men in the Assembly. If we offer the amendment, and speak for the amendment, and on roll call the amendment is defeated, if this is an administration bill, then it will be passed.

Dr. Schlichter: I don't see what else you can do. We have done all we can now.

Dr. Newcomb: If we fight for the amendment and offer the amendment and it is defeated, then we are at liberty to vote whatever way we see fit, is that the consensus of the House of Delegates, after the amendment is defeated?

Dr. Schlichter: I oppose the bill in its present form. That is the way the resolution reads —to oppose it unless the amendment goes with it.

Dr. Newcomb: If the amendment is defeated, then to oppose the bill in its original form is the correct procedure?

Dr. Schlichter: Yes.

President Lippincott: Are you ready for the question on the resolution?

The motion to adopt the resolution was put to a vote and carried.

President Lippincott: Is there any other business?

Dr. B. T. D. Schwarz (Hudson County): Mr. Chairman, the Hudson County delegation has been instructed by its members to ask consideration of the creation of a *new class of membership* to be known as *life members* or some other suitable name. The object of this proposed new class of membership is to

permit older men to enjoy the privileges of the Society without the payment of dues. In brief, we recommend that the membership be available to all men who have been members of a County Medical Society for at least 10 years and who have been in the practice of medicine more than 40 years. They shall have the rights and privileges of an Active Member except the right to vote and hold office. They shall pay no dues.

Under this proposed amendment to the By-Laws, it would not make it obligatory for any member to avail himself of this class of membership, but those members who are on in years, and have found it difficult in these times to continue paying their dues, and still want to retain their affiliation with organized medicine, would find that this class of membership would offer to them an avenue of remaining in the ranks.

In Hudson County, we have some such members. One of them was a County Society Secretary way back in 1879 and 1880, and has been in practice 56 years.

I believe the State Society should make some such provision for these members so that they may receive the Journal and other privileges that the members of the Society enjoy without the payment of any dues.

President Lippincott: Don't you think that should be in the form of a resolution to the Constitution and By-Laws Committee?

Dr. B. T. D. Schwarz: I so intend that, Mr. President. It is a recommendation to the Constitution and By-Laws Committee to draw up in suitable language an amendment.

President Lippincott: I will refer it to that Committee.

Dr. E. J. Marsh: May I say a word on that subject? I am interested to hear that Hudson County has so many venerable members. I think it is a good thing for any County Society to have, and I hope they will always have a good many venerable members of 70, 80 and 90 years of age.

The Passaic County Society has had the same situation and for 25 years or more have handled it by themselves without asking the State Society for any help. Our way of handling it is a little different than that spoken of by Dr. Schwarz, in that if we have any member who was a member of the County Society for 40 years—and we always have a number of them—he is exempt from further dues to the County Society, but the County Society goes down in its pocket for the assessment to the State. It always pays the assessment out of the treasury. We carry those members and they have full rights to hold office, to vote, or any other rights that they choose, of membership in the County Society. They are simply exempt from dues to the County Society and the County Society pays the assessment to the State Society out of its treasury.

Some time ago it was suggested by some of our members that we should ask for exemption from the State Society. It was decided not to, that we thought enough of those members to carry them ourselves, and we have done so.

As a matter of Charter right, Mr. President, I think it is doubtful, but of course that is for the Committee on Constitution and By-Laws to consider, whether a person could be exempted from assessment by the State Society and still be considered a member of the State Society, because you know no individual pays dues, it is simply a question of assessment on the County Society for every member on its roll, and if they are considered a member of the County Society, the assessment would have to be met. If they are not considered a member of the Society, there is no question about it, there is no assessment anyway. That is the way we have handled it in our county.

Secretary Morrison: Mr. President, I would like to say a word on this matter. Dr. Marsh has just touched the vital point in this whole question. The County Society recognizes members in the County Society as individuals. The State Society does not deal with individual membership. It deals with County Societies and it lays an assessment upon the County Societies that make up the amount of money expended by the treasury. So we don't receive the dues of individual members. They come in on the assessment against that County Society.

Beside the provision that Passaic County has made for these men, many of the County Societies carry men similarly. When a man gets to be 60 years of age or so, they make him an Honorary Member of the County Society, and then they send his dues to the State Society every year. Bergen County has 5 such members; several other counties have some. I think it is a matter for the County Society to take care of primarily.

President Lippincott: A motion for adjournment is in order.

Dr. Pollak: Mr. President, is the specialist bill to be considered at this session?

It was regularly moved, seconded and carried, that the meeting adjourn. Adjournment at 6.30 o'clock.

GENERAL AND SCIENTIFIC SESSIONS

Wednesday Noon Session

June 7, 1933

The first General Session of the Medical Society of New Jersey convened at 12 o'clock, noon, in the Haddon Hall Hotel, Atlantic City, New Jersey, with Dr. A. Haines Lippincott, President, presiding.

President Lippincott: Will the members be seated, please?

President Lippincott asked Vice-President Quigley to take the Chair.

Chairman Quigley: It is my happy privilege to present our President, who will deliver the Presidential Address.

President Lippincott presented his prepared Address and at the end there-of the members arose and applauded.

President Lippincott: This concludes the business of this session, and we now stand adjourned.

The meeting adjourned at 12.45 p. m.

Wednesday Afternoon Session

June 7, 1933

The General Sessions convened at 2.30 p. m., for a Symposium on Urology, Dr. A. Haines Lippincott, of Camden, President of the Medical Society of New Jersey, presiding.

Dr. Alexander Randall, of Philadelphia, presented a paper entitled "Chronic Non-Tuberculous Renal Infections". This was discussed by Drs. Edgar A. Ill, of Newark, and C. H. deT. Shivers, of Atlantic City.

Dr. Joseph F. McCarthy, of New York City, presented a paper on "Endoscopic Revision of Vesical Neck Obstructions—Its Place in Surgery of the Prostate", illustrated with slides. Discussion was by Drs. C. R. O'Crowley, of Newark; Markowitz, of Jersey City; Herman, of Philadelphia; and Herbert Ill, of Newark.

Dr. Thomas C. Stellwagen, of Philadelphia, presented a paper on "Suprapubic Prostatectomy". Discussion by Drs. Robert L. McKiernan, of New Brunswick; and I. Lerman, of Elizabeth.

President Lippincott: I have a telegram from the President of the New Jersey Pharmaceutical Association:

"New Jersey Pharmaceutical Association extends greetings and best wishes for a successful convention. We shall be pleased to cooperate with your organization at any time for the welfare of the citizens of this State. (Signed) Henry D. Kehr, President."

Dr. Stanley R. Woodruff, of Jersey City, presented a paper entitled "Tuberculosis of the Genito-Urinary Tract", illustrated with slides. Discussion was by Drs. Earl B. Stokes, of East Orange; and Samuel E. Kramer, of Perth Amboy.

At the request of Dr. William J. Carrington, due to the lateness of the hour, his paper on "Preoperative Gynecologic Care" was read by title.

The meeting adjourned at 6 p. m.

Minutes of the Evening Meeting, of Wednesday, June 7, 1933.

This "open meeting" was called to order by the President of the Medical Society of New Jersey, Dr. A. Haines Lippincott, Camden, at 9.00 p. m. and was devoted entirely to a Symposium on Medical Economics.

An Address, entitled "The Economic Relations of Medicine", was delivered by Dr. William H. Ross, Brentwood, Long Island, N. Y., Ex-President of the New York State Medical Society.

Prefacing his prepared remarks, Dr. Ross said: I am very happy to be a guest of the Medical Society of New Jersey, and I appreciate the honor of having been invited to discuss the "Economic Relations of Medicine" at a Special Session of a State Society so distinguished as yours, with its honorable record of 167 years of work in advancing the public relations of medicine.

An Address, entitled "Are we Approaching a New Era in Medicine?", was delivered by Dr. J. Bennett Morrison, of Newark, Secretary of the Medical Society of New Jersey.

Dr. John A. Hartwell, New York City, Ex-President of the New York Academy of Medicine, opened the discussion on the above-mentioned addresses, and was followed by Dr. Elbert S. Sherman, of Newark, Chairman of the Special Sub-Committee appointed from the Welfare Committee to Study the Report of the National Committee on the Costs of Medical Care.

These Addresses and their Discussions may be found, published in full in the Journal of August 1933.

At the suggestion of the President, a rising vote of thanks was extended to the speakers of the evening, and adjournment was voted at 11.15 p. m.

Thursday Afternoon

June 8, 1933

The General Session convened at 2.15 p. m., with the President, Dr. A. Haines Lippincott, in the chair.

Dr. David Riesman, of Philadelphia, presented a paper on "Disease of the Coronary Arteries". It was discussed by Drs. Louis F. Bishop, Sr., of New York City; Elton S. Corson, of Bridgeton; J. Bennett Morrison, of Newark; and H. I. Goldstein, of Camden.

Dr. Albert S. Hyman, of New York City, then discussed the subject "Some Phases of Electrocardiographic Work", showing lantern slides and moving pictures. Discussion was by Drs. L. F. Bishop, J. B. Wolfee, A. B. Cantor, H. I. Goldstein, E. S. Corson, and, in closing, by the essayist.

President Lippincott: Is Dr. Danns in the room?

Dr. Danns: The announcement which I have to make should, I think, have been made by our President, but he has insisted that I must, so, Mr. President, here we go.

Dr. Lippincott appointed 3 Judges to look over the "Scientific Exhibit" and determine the relative value of the contributions. One of the judges was an internist, one a roentgenologist, and the other a pathologist; but all desire that their names be omitted from this report. I might say that none of the Judges was in any way connected with any institution from which material was displayed, and the *awards were based upon the general character and extent of the exhibit, its originality, and its educational value.*

The material was divided into 3 classifications: (1) roentgenologic, (2) pathologic, and (3) general. It was very difficult for the Judges to arrive at decisions in some instances; because there is so much good material there, that has represented so much time and preparation, and I personally want to thank the exhibitors as well as the Judges for the work.

The first award, that in the pathologic exhibits, was given to Dr. A. R. Cassili, of the Elizabeth Hospital, at Elizabeth, for reproduction of pathologic specimens in plaster.

The second award was made to Drs. Jerome M. Lynch and Joseph Felson, of Polyclinic and Bronx Hospital, New York, for "Tumors of the Colon and Rectum". Dr. Felson made a wonderful sacrifice to put up the exhibit, because just after putting it up, he fell and suffered an injury to the surgical neck of the humerus, and that will prevent him from taking the exhibit on to the American Medical Association in Milwaukee, as he had planned to do.

For the radiologic exhibit, the first award is made to Dr. B. S. Pollak, of Hudson County Tuberculosis Hospital, Secaucus, N. J., for "Clinico-Pathologic Studies in Pulmonary Tuberculosis", and the second award is given to Dr. Francis C. Grant and Dr. C. Frazier, of University Hospital, Philadelphia, for "Encephalography and Ventriculography".

In the general classification, Dr. Albert S. Hyman, of the Witkin Foundation for the Study and Prevention of Heart Disease, Beth David Hospital, New York City, received the first award for "Precordial Lead Electrocardiography".

The second award is made to Drs. Barton Young and C. L. Jackson, of the Department of Radiology, and Chevalier Jackson, Bronchoscopic Clinic, Temple University, Philadelphia, Pa., for "Bronchial Tumors: A Correlation Between Roentgenoscopic and Bronchoscopic Appearances".

President Lippincott: Dr. Danns, on behalf of the Society, I want to thank you for taking charge of this Scientific Exhibit. I know it has been hard work and you have done wonderfully well.

Dr. Elton S. Corson (Bridgeton): In view of the reported accident which occurred to Dr. Felson, I move that we extend to him the sympathy of the Society.

The motion was regularly seconded, was put to a vote, and was carried.

Dr. Lesile E. Myatt, of Bridgeton, presented a paper on "An Unique Operation for Appendicitis".

Dr. D. Ward Scanlan, of Atlantic City, read a paper entitled "Agranulocytosis".

President Lippincott: Before opening the discussion on this paper, I want to say that Dr. Mahaffey did not see my address before he wrote this letter, I know, but I have a very fine letter from the State Board of Health offering their coöperation to the Medical Society of New Jersey and the physicians of New Jersey, the same as ever. Dr. Mohaffey, I thank you.

Discussion on Dr. Scanlan's paper followed by Drs. S. Barbash and George Poland.

The next paper, "Lead Absorption and Lead Poisoning, with an Analysis of Over 100 Cases", by Dr. Otto Lowy, of Newark, was read by Dr. Louis J. Livinson, due to Dr. Lowy's ill health. Discussion was by Drs. Max Kummel, of Newark, and H. I. Goldstein.

The meeting adjourned at 5.40 p. m.

Friday Afternoon

June 9, 1933

The meeting convened at 2 p. m., with President Lippincott presiding.

Dr. R. B. Walker, of New Brunswick, presented a paper on "Urographic Findings in Toxemia of Pregnancy", illustrated with slides. Discussion was by Drs. Robert L. McKiernan, of New Brunswick; and J. J. Strump, of Jersey City.

Dr. Philip F. Williams, of Philadelphia, read a paper on "The Avoidable Factors in Maternal Mortality". Discussion was by Drs. Robert MacKenzie, of Asbury Park; and Albert B. Davis, of Camden.

Dr. Lippincott then declared the meeting adjourned, at 4 p. m., and it resolved itself into a Conference of the Maternal Welfare Commissions of the County Societies, which was conducted, informally, by Dr. A. W. Bingham, of East Orange.

SECTION ON OPHTHALMOLOGY OTOLOGY AND RHINOLARYNGOLOGY

Wednesday Morning Session

June 7, 1933

The first session of this Section convened at 10 a. m., in the Mandarin Room of Haddon Hall, with Dr. Charles H. Schlichter, of Elizabeth, its chairman, presiding.

Dr. William Brewster Allan (Englewood), presented a paper entitled "Fibroma of the Nasopharynx".

Discussion followed by Drs. Henry C. Barkhorn, James A. Fisher, Browne Morgan, and, in closing, by the essayist.

Dr. V. Earl Johnson (Atlantic City), presented a paper on "Avertin Rectal Narcosis".

Dr. Sinkinson, of Atlantic City, who was to have discussed the paper, was absent. Dr. Charles S. McGivern, therefore, opened the discussion, and was followed by Drs. S. Stalberg, Elias J. Marsh, Henry Barkhorn and H. B. Wilson, and, in closing, by the essayist.

The meeting adjourned at 11.45 a. m.

Thursday Morning

June 8, 1933

The meeting opened at 10 a. m., Dr. Schlichter presiding.

Chairman Schlichter: Before starting on the scientific papers, Dr. Marsh has a matter to bring before the session.

Dr. Elias J. Marsh (Paterson): Mr. Chairman, recently I happened to hear the public statement of the Knapp Memorial Fund of the Ophthalmic Section of the American Medical Association. It occurred to me we have in the list of Fellows of our own Society the name of one who, in the last third of the 19th century had no mean place among the leaders of ophthalmology and otology; a man whose name, even to this day, is recognized as outstanding in ophthalmology in New Jersey; one who, without having attained quite the dazzling height of Knapp's name in ophthalmology, still, coming from the same country as Knapp but as a younger man, attained probably a higher standing in the citizenship of his adopted country than even the illustrious Knapp.

His name is already commemorated in the Eye and Ear Infirmary which he founded, and also on the map of our State, but it occurred to me it might be proper for us to do something in the way of establishing a Charles J. Kipp Memorial through the activity of this Section. It is a matter that requires some consideration.

It is no derogation of the credit or fame of a man to say that a memorial is not necessarily desirable. Also, if desirable, it might not be practicable under all circumstances. But my suggestion is that the Chairman and ex-Chairmen of this Section (all who have acted as Chairmen of this Section in the past) be asked to act as a Committee to consider during the next year, and report to us next June, first, how far the establishment of such a memorial might be desirable, and second, if desirable, whether it is practicable, and third, if practicable, what form it should take.

I would like to offer a motion to this effect.

The motion was seconded, put to a vote and carried.

Dr. R. N. Berke, of Hackensack, then presented a paper on "Use of the Cylinder in Refraction", illustrated with slides. Discussion was opened by Drs. J. S. Shipman, A. R. Sherman, Browne Morgan, E. J. Marsh, O'Connor, and by the essayist.

Chairman Schlichter then announced the Nominating Committee, whose report would be made at the close of Friday's scientific session. The Committee was: Drs. Fisher, Morgan and Shipman.

Dr. Dennis M. O'Brian (Passaic), then presented a paper on "Hyperplastic Ethmoi-

ditis"; which was discussed by Drs. Raymond Creasy and G. E. Pauley (Queen's Village, Long Island).

Dr. Lewis W. Brown (Newark), presented a paper on "Management of Vasomotor Rhinitis from the Standpoint of the Allergist", illustrating with slides. Discussion was opened by Dr. Henry Barkhorn, and followed by Dr. Alfred Mamlet, of Newark.

Dr. Oram R. Kline (Camden), presented a paper on "Conservative Treatment of Chronic Suppurative Otitis Media", illustrated with slides. Discussion followed by Drs. Edward A. Atwood, James A. Fisher, Alfred Mamlet, and, in closing, by the essayist.

The meeting adjourned at 12.15 p. m.

Friday Morning

June 9, 1933

The meeting convened at 10 a. m., with Dr. Schlichter presiding.

Chairman Schlichter: I have already, on behalf of this Section and of the State Medical Society, offered my apology to Dr. Samuels and Mr. Burchell for the small attendance. I have assured them it was not because they were here, but it was the case in all sections, because, owing to a resolution passed by the House of Delegates to do away with the Friday afternoon legislative session, most of the men have gone home. Economic conditions have had a good deal to do with that but, as Chairman of this Section, and as this is to be published in the Transactions, I want to go on record and say that I think some of our members might have stretched a point to stay over and hear these 2 interesting discussions.

I am going to ask Dr. Bernard Samuels, of New York, to open the proceedings this morning with his talk on "Perforating Wounds of the Eye".

Dr. Samuels of New York presented his subject, "Perforating Wounds of the Eye", showing a series of slides.

Chairman Schlichter: Those of us who remained have, I think, been well repaid, and those who stayed away have sustained a loss that will be hard for them to make up. This demonstration has certainly been of interest and one that no ophthalmologist can afford to miss.

I thank you, Dr. Samuels, for talking to so few of us. My apology is again offered for the small number who remained.

The Committee on Nominations I believe has a report to make.

Dr. Browne Morgan: The Committee suggests the following: Chairman, Dr. Samuel T. Hubbard, Hackensack; Vice-Chairman, Dr. James A. Fisher, Asbury Park; Secretary, Dr. George S. Laird, Westfield.

Upon motion duly made and seconded, the nominations were closed and the Secretary instructed to cast one ballot for the gentlemen named.

Chairman Schlichter: Mr. Burchell has a fine collection of forms here, and I would suggest that we make his talk informal by gathering around the table and going over his exhibit with him.

Informal discussion and examination of Mr. Burchell's specimens of temporal bones followed.

SECTION ON PEDIATRICS

Wednesday, June 7, 1933

The Section on Pediatrics convened in the Viking Room, of Haddon Hall, Atlantic City, on June 7, 1933, and was called to order at 9.30 a. m. by the Chairman, Dr. Frank C. Johnson, New Brunswick.

Papers were read and discussed as follows: (1) "Indications and Symptoms of Surgical Mastoiditis in Infants", presented by Dr. William J. Greenfield, Hackensack. This was discussed by Drs. Kenneth Blanchard, East Orange; H. P. Fine, Perth Amboy; and, in closing, by the essayist.

(2) A paper was read by Dr. Le Roy Wilkes, New York City, entitled "Public Health Responsibility of the Pediatrician", and discussed by Drs. Stanley H. Nichols, Asbury Park; F. I. Krauss, Chatham; D. W. Teller, Morristown; Julius Levy, Newark; Frank C. Johnson, New Brunswick; E. J. Thalheimer, Vineland.

(3) A paper was read by Dr. Henry B. Orton, Newark, entitled "Bronchoscopy in Infancy and Early Childhood", and discussed by Drs. William J. Greenfield, Hackensack; Frank C. Johnson, New Brunswick; and, in closing, by Dr. Orton.

(4) A paper was presented by Dr. Robert A. Cooke, New York City, entitled "The Causes and Management of Asthma in Children". The Chairman stated that this Section was very happy to have Dr. Cooke speak

about asthma in children; that many of the members have called upon him in time of trouble and thus increased the number of his non-paying patients considerably; that his experience is very highly valued. This paper was discussed by Drs. M. L. Ripps, Elizabeth; Hyman I. Goldstein, Camden; F. W. Lathrop, Plainfield; F. I. Krauss, Chatham; and, in closing, by Dr. Cooke.

The Session adjourned at 12 noon in order to listen to the President's Address.

Thursday, June 8, 1933.

The Session reconvened at 9.30 a. m., being called to order by the Chairman, Dr. Frank C. Johnson.

(5) A paper entitled "Recurrent Vomiting" (A Child Study) was presented by Dr. F. I. Krauss, Chatham, and discussed by Drs. Thomas P. Prout, Summit; F. W. Lathrop, Plainfield.

(6) A paper entitled "Asphyxia Neonatorum" was read by Dr. Arthur Heyman, Newark, and discussed by Dr. I. B. Rothstein, Newark.

(7) A paper entitled "The Initial Stabilization of the Juvenile Diabetic" was presented by Dr. John Mitchell Brush, New York City, and discussed by Drs. Arthur Heyman, Newark; H. I. Goldstein, Camden; and, in closing, by the essayist.

(8) A paper entitled "Congenital Hypertrophic Pyloric Stenosis in Infancy" (A report of 30 patients operated on at Cooper Hospital, Camden), was read by Dr. Ernest G. Hummel, Camden, and discussed by Drs. Vincent Del Duca, Camden; H. I. Goldstein, Camden; F. W. Lathrop, Plainfield; M. L. Ripps, Elizabeth.

(9) Dr. Edward J. Donovan, New York City, presented a paper entitled "Abdominal Surgery in Infants and Children".

Chairman Johnson requested that Dr. Donovan discuss Dr. Hummel's paper, before presenting his own paper, and that discussion of the 2 papers be continued after the presentation of his own. That plan was followed and the discussion was continued by Dr. Donovan, New York City; Drs. Ernest G. Hummel, Camden; Arthur Heyman, Newark; F. C. Johnson, New Brunswick; and Edward J. Donovan, New York City.

Nominating Committee, previously appointed by the Chair, proposed Dr. Walter B. Stewart, of Atlantic City, for Chairman of the Section on Pediatrics for the ensuing year, and he was duly elected by unanimous vote of the Section.

(10) A paper entitled "Congenital Syphilis, and Its Treatment by Oral Administration of Arsenic in the Form of Stovarsal", was read by Dr. Benjamin M. Joseph, Jersey City, and discussed by Dr. Julius Heilbrunn, Jersey City.

Adjournment at 1 p. m.

Friday, June 9, 1933

Joint Session, School Physicians and Pediatricians.

SECTION OF SCHOOL PHYSICIANS

Wednesday Morning

June 7, 1933

The session convened at 9.35 a. m., with Dr. Allen G. Ireland, Chairman, of the State Department of Public Instruction, presiding.

Dr. Ireland stated that he hoped to make the program more attractive this year by setting up a series of pertinent topics for discussion.

(1) "What Can Be Done to Decrease the Incidence of Parasitic Skin Diseases Among School Children?" This was discussed by Drs. Harry L. Rogers, of Riverton; Emlen P. Darlington, of New Lisbon; D. W. Green, of Salem; A. B. Coultas, of Madison; Jacob M. Davis, of Burlington; E. N. Huff, of Englewood; Joseph Schapiro, of Union City; and Grace M. Kahrs, of Jersey City.

(2) "What Nutritional, Mental, Emotional and Pathologic Conditions May We Expect to Find in Children and Youths During the Next Few Years, as Results of the Economic Depression of 1929-1933?" This was discussed by Drs. E. N. Huff, of Englewood; George Knowles, of Ridgefield Park; Ralph K. Hollinshed, of Westville; and D. S. Renner, of Skillman.

(3) "What Pre-School Work May Reasonably be Expected of the School Physician, Assuming the Contractual Agreement Is in Force?" This was discussed by Drs. Julia C. Mutchler, of Dover; George Knowles, Helen F. Schrack, of Camden; Pierce Shope, of Camden; Wilbur A. Smith, of Oaklyn; Stanley H. Nichols, of Asbury Park; Ralph K. Hollinshed, Jacob M. Davis, Joseph Schapiro and Donald B. Hull, of Ridgewood.

Dr. E. H. Kleinschmidt, Director of Health Education for the National Tuberculosis Association, then read a paper on "Tuberculin Testing of Children". This was further discused by Dr. Kleinschmidt, in answer to questions from the audience.

The meeting adjourned at 11.50 a. m.

Thursday Morning

June 8, 1933

The morning session convened at 9.45 a. m., the Chairman, Dr. Allen G. Ireland, presiding.

Dr. Ireland introduced Dr. E. N. Huff of Englewood. Dr. Huff had intended to present a paper entitled "A Complete Final Physical Examination for Graduating High School Students", but, as the examination upon which the paper was to be based did not materialize, due to lack of funds, there was no material for such a paper. Dr. Huff talked briefly, therefore, on the idea embodied in the above title. Discussion then followed, by Dr. Ireland, Dr. Julia C. Mutchler of Dover, Dr. Mable Grier Lesher of Camden, Dr. Frederick A. Kinch of Westfield, Dr. J. W. Demarest of Hackensack.

Dr. Dan S. Renner, Superintendent of the Village for Epileptics at Skillman read a paper entitled "Epilepsy in School Children".

Discussion by Dr. Ireland.

Dr. J. W. Demarest (Hackensack) read a paper entitled "Some Phases of Pre-School Examinations in Hackensack".

Discussion by Drs. Ireland; E. N. Huff, of Englewood; Samuel Stalberg, of Atlantic City; Donald B. Hull, of Ridgewood; C. R. Brown, of Arlington; Joseph Schapiro, of Union City; Julia C. Mutchler, of Dover; Mr. Edward Whitehead, Executive Secretary Bergen County Medical Society, of River Edge; Norman L. Rowe, of Jersey City.

The meeting adjourned at 11.53 a. m.

Friday Morning, June 9, 1933

Joint Session, School Physicians and Pediatricians.

JOINT SESSION, SCHOOL PHYSICIANS AND PEDIATRICIANS

Friday Morning

June 9, 1933

The meeting convened at 10 a. m., Dr. Frank C. Johnson, of New Brunswick, presiding.

Dr. F. W. Lathrop, of Plainfield, read a paper entitled "Ulceromembranous Stomatitis".

This was discussed by Drs. Allen G. Ireland and Frank C. Johnson.

Dr. Meredith F. Campbell, of New York City, read a paper entitled "Surgical Diseases of the Upper Urinary Tract in Infants and Children".

Discussed by Drs. A. Haines Lippincott, of Camden; F. W. Lathrop, and Meredith F. Campbell.

Dr. I. J. Wolf, of Paterson, read a paper entitled "The Etiology of Dyslalia".

Discussed by Drs. E. A. Atwood, of Paterson; Maurice L. Ripps, of Elizabeth; and F. W. Lathrop.

Dr. Maurice L. Ripps read a paper entitled "Scarlet Fever Prevention by Inunction with Toxin".

Discussed by Drs. F. W. Lathrop, Joseph Schapiro and Frank C. Johnson.

Adjournment at 11.40 a. m.

SECTION ON RADIOLOGY

Wednesday Morning

June 7, 1933

The meeting was called to order by the Chairman, Dr. Charles B. Kaighn, at 10.30 a. m.

Dr. E. Reissman, of Newark, scheduled to present a paper on "A Case of Mediastinal Dermoid Cyst, with Operation", apologized that he did not have a paper prepared, due to the fact that "the notice that something might be needed came a little late". He presented a talk on this subject, which was illustrated with films, pictures, and a specimen.

Dr. F. Maurice McPhedran (Philadelphia), scheduled to present a paper on "Progressive Increase of Roentgen Ray Findings in Pulmonary Tuberculosis, with Gain in Weight",

showed instead many slides, discussing each as shown.

This presentation was discussed by Drs. Benjamin Paul Potter, Samuel B. English, E. Reissman, Marcus W. Newcomb, Berthold S. Pollak, Charles I. Silk, and S. F. Wade.

Dr. Solomon Weintraub (Harlem Hospital, New York), presented a paper on "Cardiovascular Syphilis: Analysis of 1730 Autopsies".

The meeting adjourned at 11.55 a. m.

Thursday Morning
June 8, 1933

The meeting convened at 10.05 a. m., Chairman Kaighn presiding.

Dr. S. A. Goldberg, (Newark), presented a paper on "Carcinoma of the Small Intestines".

Discussion followed by Drs. Charles F. Baker, William Klein and William W. Mayer.

Dr. R. Pomeranz, (Newark), presented a paper on "Critical Evaluation of the Newer Radiologic Methods of Gastro-Intestinal Examination".

This paper was discussed by Drs. Charles F. Baker, William Klein, S. A. Goldberg, and William W. Mayer.

Dr. Karl Bornblum, of the Radiologic Department of the University of Pennsylvania, presented a paper on "Studies of the Small Intestine".

Dr. Robert P. Sturr, of the Staff of the Post-Graduate Hospital, presented a paper on "Roentgen Ray Changes in Intestinal Obstruction".

The meeting adjourned at 12.20 p. m.

Friday Morning
June 9, 1933

There was no meeting, because of there being no audience.

Dr. Milton Friedman (Newark), was scheduled to present a paper on "Malignant Neoplasms in the Young", and *Dr. Bernard F. Widman* (Philadelphia), also turned in his manuscript on "The Treatment of Parotid Tumors with Roentgen Rays and Radium".

SIXTH ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

At Haddon Hall, Atlantic City, Thursday, June 8, 1933

The meeting was called to order at 10 a. m., by the President, Mrs. Charles Franklin Adams.

Mrs. Frank J. Altschul, Secretary, read the minutes of the regular meeting of the Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey, which was held in Atlantic City, June 7, 1933, and the minutes of the last Annual Meeting, which was held in Atlantic City, June 16, 1932. On motion, the minutes were approved as read.

The President reported that some changes have been made in Committee Chairmen during the past year: Mrs. Maurice Chesler, of Atlantic City, resigned and Mrs. James North, also of Atlantic City, took her place. Mrs. George H. Rogers, of Newark, was appointed Chairman of the Public Health Committee, and Mrs. McConaghy was appointed Chairman of the Hygeia Committee.

Treasurer's Report

The Treasurer, Mrs. Edward W. Clarke, read the financial report. It was regularly moved, seconded and carried that this report be accepted. The Auditing Committee reported that the books had been examined and found correct.

For 1932

		General Fund	Annual Meeting Fund
Balance, June 15, 1932		$166.89	$257.55
Receipts General Fund:			
Dues and arrears	$375.50		
Bill heads	.75		
Refund from President of over-due payment	10.87		
		387.12	
		$554.01	
Receipts Annual Meeting Fund			82.00
			$339.55
Disbursements General Fund:			
Initiation fee and dues for N. J. Federation	$ 10.50		
Printing, supplies and postage	78.35		
Tribute to National President	10.00		
Federal Tax on checks	.28		
1932 dues to A. M. A.	182.75		
Rental of Club House on Jan. 9	15.00		
President's Pin	21.10		
		$317.98	
Balance General Fund			$236.03
Disbursements Annual Meeting Fund:			
Stenographer's services	$ 10.00		
Printing Luncheon tickets	3.00		

Guest Luncheon and tips	25.00		
Flowers	30.00		
		$ 68.00	
Balance Annual Meeting Fund		$271.55	
Balance General Fund			$236.03
Balance Annual Meeting Fund			271.55
Bank Balance June 8, 1933			$507.58

It was regularly moved, seconded and carried that this report be accepted. The Auditing Committee reported that the books had been examined and found correct.

REPORTS OF THE STANDING COMMITTEES

Press and Publicity Report

Mrs. North: There are 15 active County Society Auxiliaries in the State, and each has a press and publicity committee Chairman. Of the *Local Chairmen* 11 coöperated by sending in reports of their meetings; Camden, Gloucester and Hudson sent exceptionally good reports; 44 such articles were sent to the State Journal and all were used. Annual reports were sent to the Regional and National Chairmen.

This Report was accepted by a motion duly seconded and carried.

Program Committee Report

Mrs. Hutchinson: The Program Committee arranged the meeting at which Dr. Mahaffey, Director of the State Department of Health, spoke on "Welfare Work". Arrangements were also made for the Annual Meeting, in Atlantic City, holding the business sessions at Haddon Hall Thursday morning, June 8. Dr. Edw. J. Ill, of Newark, will address the luncheon meeting, on the subject of "Widows and Orphans Relief Fund".

By a motion, duly seconded and carried, the Report was accepted.

Public Health Committee Report

Mrs. Rogers: Owing to the lateness of my appointment, not many satisfactory accomplishments were made in the health program. I communicated with the different chairmen and asked them if they had received Literature and Outlines, and also asked that they place before Women's Clubs and Parent-Teacher Associations pamphlets put out by the American Medical Association. I also sent out this questionnaire—"How many speakers have addressed your meetings on your *study outlines* used by Auxiliary members?" "Do you prepare a study outline for your County and how many health pamphlets prepared by the A. M. A. have you distributed?" I also asked if they had any other information connected with the health program in their County. The results were not encouraging from the health education point of view.

Some of our County Auxiliaries have no such Committee, and where there is a Committee, efforts have been mostly in furthering the interests of *Hygeia*. Essex and Hudson distributed 150 pamphlets before the Parent-Teacher Associations and Women's Clubs; none of them had used the study outlines, and only one prepared a study outline. I trust that this preliminary work will be of assistance to my successor.

This report was accepted by a motion duly seconded and carried.

Entertainment Committee Report

Mrs. Haggerty: The Entertainment Committee has for its special work the arranging of the *Annual Luncheon*, which we have today at 1 p. m. in the Rutland Room. Tickets will be $1.50. To the people in the hotel on the American Plan, there will be no charge made, and those on the European plan in the hotel and other guests will pay $1.50. Our speakers will be *Dr. E. J. Ill* (Newark), who will speak on the "Widows and Orphans Fund"; *Dr. A. Haines Lippincott*, the Retiring President, and *Dr. Frederic J. Quigley*, the In-coming President; *Mrs. Charles Franklin Adams*, our outgoing President; and, *Mrs. Harry Hubbard*, our In-coming President. We would like very much now to learn how many are coming to the *luncheon*. I move my report be accepted.

By motion duly seconded and carried, this Report was accepted.

Public Relations Committee Report

Mrs. Casselman: Your Chairman has tried to follow the recommendations of the National Chairman. I have sent to 16 Counties the recommendations of the National Chairman at the beginning of the year's work; also a "study envelope" of each of the subjects outlined. I sent to the National Public Relations Bureau for all the material that could be given me. I offered to furnish these study envelopes but had no calls for them. Some were distributed at the Gloucester County reciprocity meeting, and many were distributed at the Camden County reciprocity meeting. I sent out a questionnaire in April, in regard to the work that had been done by the auxiliaries, and at the end of the year we had 8 counties with Public Relations Committee Chairmen. I heard from 8 of those counties. All 8 counties have had reciprocity meetings. One County Auxiliary had secured 24 speaking engage-

ments before Parent-Teacher Associations, Women's Clubs, etc. I believe it is progressing and urge you to continue with your Public Relations work.

By motion, duly seconded and carried, the Report was accepted.

Hygeia Committee Report

Mrs. McConaghy: It is with regret that I report the inactivity of our Committee on Hygeia, because of high subscription cost and lack of interest. The resignation of the Chairman appointed June, 1932, was accepted and I, myself, appointed January, 1933. Our President, Mrs. Adams, requested each County Chairman for reports, but I received 2, only. If the individual County members will not interest themselves in Hygeia, it can not be expected that laymen will. The following is quoted from the A. M. A. Bulletin of April, 1933: "It is indeed gratifying to the Board of Trustees to be able to report that the income received by subscriptions to Hygeia, and with the sale of advertising space, was greater than the production cost by the sum of $18,768." Many auxiliary members report —what is there for us to give? Here is work given us to do and it is not for us to ask how or why, but to do or die. The State has a record of a total of 54 subscriptions for the year.

Motion, duly seconded and carried, accepted this Report.

Organization Committee Report

Mrs. Snavely: I have communicated with 14 counties enclosing the sample membership blank and also a follow-up letter which could be sent to members. A few other suggestions were made which had been helpful in some of the counties, to increase their membership. We are pleased to announce that our membership has increased by 127 since last June and that the prize will be awarded to Monmouth County; and Passaic second.

By motion duly seconded and carried, this Report was accepted.

Credentials and Registration Report

Mrs. Scott: There are 72 present. It is a little difficult to tell how many of the Executive Board because some of them are Delegates. There are 12 counties represented.

Motion duly seconded and carried that this Report be accepted.

President Adams: Have I omitted any standing committees? I think not. We will now call on the different Counties because I am anxious to know what some of you are doing.

County Society Reports

Atlantic. A very pleasant time was had at our Card Parties. We have had quite a number of Card Parties to produce funds for charitable purposes. We have been having *tea bridges* at various homes of the members in the afternoons instead of the evenings, with a meeting in the beginning of the afternoon and tea bridge afterward. This seemed to bridge the formality and make for greater friendliness.

Bergen. Our Auxiliary had its regular monthly meetings, each of which had an educational program as well as its business meeting. Our first meeting we had a delightful speaker, Mrs. Edith L. Stockley, on the subject of the relations of a physician's wife to community health program. On November 15, we visited Plainsboro, New Jersey. A bus was furnished which conveyed us comfortably to the plant, where we had a delicious luncheon. Then we were escorted through the laboratories and around the farm, and then we were driven through Princeton and back to Hackensack. The whole day was most enjoyable as well as educational, and at no cost. Another one of our speakers was Miss Audrey Grace Adams, who gave us an enlightening talk about "Cheese", stressing its nutritional value, and the nationally different cheeses. We were also fortunate to secure Dr. Herbert J. Stack to address us. Dr. Stack is instructor at Columbia and Rutgers Universities and, in a very pleasant manner, he presented his topic— "What Price Accidents" and illustrated with lantern slides. One of our most interesting meetings was one at which Miss Edna Young Bond, of New Jersey Tuberculosis League Parenthood, addressed us. A very interesting discussion followed the talk. We had one informal meeting at Bergen, where our President, Mrs. Joseph Morrow, entertained the officers and members. We also had our Annual Card Party which was a social as well as a financial success. During the year, there were 3 resignations of members but there were also new memberships to counterbalance. Our membership is small. We have but 33 members, most of whom, however, are intensely interested in the Auxiliary. At Christmas, we gave donations of $25 each to the 4 hospitals in the County; not a great amount, to be sure, but an aid in a small measure toward Christmas cheer for those unfortunate enough to be ill at that festive season. We had 2 Executive Committee meetings during the year and, in May, we had our annual election of officers.

Burlington. I am sorry that our report isn't quite complete. I don't mean that we haven't tried but we have had a very discouraging year. Our first meeting was held the first week of November at the Burlington County Hospital in Mt. Holly, where we made our plans for the year and at this time made our annual donation to the hospital. On February 27, we held our reciprocity meeting at Moorestown Community House. Dr. Knight, of Pitman, was our speaker and gave us a splendid talk on the progress of medicine and hygiene. At our annual luncheon, May 18, at the Spring Hill Country Club, Maple Shade, Mrs. Adams honored us, bringing with her Mrs. Hutchinson and her daughter. Election of Officers was held and Delegates to convention at Atlantic City were appointed. Mrs. H. R. Rogers, of Riverton, has consented to act as our Public Relations Committee Chairman. We haven't had any up until this time. It has been a discouraging year and members have not come out to attend our meetings, but we have

tried to answer our correspondence carefully, and carry out instructions received.

Camden. I want to say that I consider the County Auxiliary presidency equal if not greater in importance than that of State or National presidency. I feel that without our County units alive and active, that we could not have a State or National Auxiliary, so I am asking you all to aspire to the office of County President. Four league meetings of the Woman's Auxiliary to the Camden County Medical Society have been held during the fiscal year, namely, in October, January, March, and the Annual Meeting and Election of Officers in May. At all of these meetings, delightful educational programs were given by outstanding speakers on health and other subjects in which our group is interested. In October, a benefit Card Party was held which netted over $200, and $150 of this was contributed to the Camden County Tuberculosis Association. A public relations meeting was held in February under the leadership of Mrs. Arthur J. Casselman, Jr., to which the officers of all women's organizations in the County were invited. A large and appreciative group attended and much of our educational material was distributed. We are endeavoring to follow up work with the groups who have shown interest in our study programs. A special meeting was held in March to hear the committee appointed by the President, Mrs. David F. Bentley, Chairman, with Mrs. Joseph E. Roberts, Mrs. Thomas Lewis, Mrs. Gordon F. West and Mrs. Arthur J. Casselman, Jr., enlighten us in regard to the report on the costs of medical care. The committee worked very hard on this program and helped us very much in the understanding of this new challenge to the medical profession.

Besides the Auxiliary's contribution to the Tuberculosis Association, we have purchased eyeglasses for 20 school children and bought 2 braces for crippled children. The physician's wives of Camden County have talked the vision of the Auxiliary and we have increased our membership by 22 members, giving us a total membership of 63. The increase in membership has been due largely to the efforts of Mrs. Bentley and her Committee on Membership. At the Annual Meeting in May, the officers were elected. We are vitally interested in the work for the coming year and as soon as the national convention in Milwaukee is over, a definite program will be arranged. We thank the State Auxiliary for helpful suggestions and advice, and pledge our loyal support to the incoming administration.

Essex. In the 4 general meetings, each of which was preceded by 1 or 2 meetings of the Executive Board, Essex County has done its best to carry out the policies which have been shaped and developed by the leaders of the Auxiliary to the American Medical Association. With the help of a splendid Executive Board, consisting of 15 women, we have tried to comply with their program. It has been customary in our County to invite the President of the County Medical Society as guest speaker at the first meeting of the season. Besides Dr. Areson, other speakers during the year were Dr. Charles Englender, who gave an interesting account of the care of the patient at the Essex County Hospital at Overbrook, for the Insane. Dr. Walter Mount, President of the Maternal Welfare Commission, told us of the work done by that group of physicians in Essex County. In order to carry out the recommendations of the National Chairman of Public Relations, a reciprocity meeting was held in March when Mrs. Taneyhill, Field Secretary of the State Medical Society, and Dr. James Howard, of the Essex County Juvenile Clinic, were the speakers. This proved to be the outstanding meeting of the year. The "teas" which have followed each meeting have done much to promote acquaintanceship among our members. In many cases, an intimate contact has been established between physicians' families, that had not existed before. The Chairman of the Membership Committee has been most active in her endeavor to procure new members and has continued to send application blanks to the wives of members of the County Medical Society who have not yet joined the Auxiliary. A *membership drive* in the form of a "bridge" will be held on June 14, for which 700 invitations have been sent to wives of members of the Essex County Medical Society who are not members of the Auxiliary. Over 500 application blanks have been sent for the second time to wives of physicians who have not joined the Society for the Relief of Widows and Orphans. That society has added 25 new names of Essex County members to their list. And they are giving the Chairman of our Auxiliary credit for this large increase in membership in our County. I should like again to stress the importance of this organization. Unless one has heard, as I have at the Annual Meeting, of the destitute condition in which the wives of some physicians have been left, it would be hard to realize that such poverty exists among physicians' families, men who once held a prominent place in medical circles. The Trustees of the Society have found it difficult to ascertain the names of those who may be in need of their aid, and are glad to be notified of any needy case. They do not consider this a charity but a right to which widows and orphans of physicians are entitled. The Chairman of the Social Committee and her assistants have spared no efforts in making the social part of our program attractive. The credit for a successful evening bridge party goes to this committee. The proceeds, which were over $200, were added to the scholarship fund, which now exceeds $1000. Two contributions amounting to $75 were given to an emergency milk fund of the babies' hospital in Newark and to the fund for needy cases.

Handbooks issued by the National Auxiliary have been purchased and given to every member of our Executive Board. Two days were spent by groups in visiting the Newark Board of Health and Dispensary and the Newark City Hospital. In conclusion, let me express the hope that our efforts during the past year have helped the cause of the Auxiliary toward accomplishing its aims.

Report of the Widows and Orphans Fund, by Mrs. Orton:

This is the first Annual Report of the Auxiliary assisting the Committee for the Relief of Widows and Orphans of Medical Men of New Jersey. Last Fall, we received an invitation to help in this work and we proceeded at once to get things underway. Letters were sent out to each County asking that a Chairman be appointed to head up this work. At the January meeting of the Executive Board word was received from several counties that the work was progressing favorably. This being a new venture, it takes time, necessarily, to get each County into operation. The middle of May a letter was sent out asking for reports by June 1 and the following is the result of that letter:

Today we have reports from Monmouth that they have had 9 new members and 5 more promised and Essex County—25. Essex County has been the banner county so far in this work throughout the

year and we appreciate the efficient work of Mrs. Walshouser and the Committee. She is the Essex Chairman.

Gloucester. We opened our meetings in September with a luncheon and that was to celebrate our fifth birthday. In October we had a reciprocity meeting and had Dr. Wilmer Krusen, from Philadelphia, address us on "Women's Work in Health and Welfare". We had 80 guests at this affair. In December, at Christmas, we had a talk from an old lady, 80 years old, who lives in the County. She displayed costumes of 1880 and distributed Christmas gifts. In February we thought we would have an educational talk on cancer. This was attended by 7 members—the *old standbys*—no one else turned out. In March we had a meeting and a woman from Philadelphia was our speaker. We had 75 present. This was our outstanding program for the year. In April, we entertained the Gloucester County Medical Society. We had Dr. Ivan Griffith, from the Philadelphia College of Pharmacy, give a talk on the "Cosmetic Urge". Everyone said they enjoyed it very much. In May, we had a luncheon and elected officers.

Hudson. The Woman's Auxiliary to the Hudson County Medical Society has a membership of 100, including wives, sisters and daughters of physicians. We hold our meetings on the first Monday in the month from October to May. We have had 7 meetings, not including January. The meeting day fell on New Year's. Of these meetings 3 have been card parties. We had a reciprocity meeting when representatives from all the organizations in the County, also many of our staff officers were invited to join us. Our President, Mrs. Charles Franklin Adams, attended our January card party and also came to our reciprocity meeting, and many other State Officers have been our guests during the season. The Field Secretary of the State Medical Society was our guest speaker in March, giving us her most interesting new lecture. Mr. Coleman, Director of Relief in Passaic and Clifton, gave us a talk on his trip abroad, which was an extremely interesting and instructive lecture. He also spoke on a trip to Russia. At our reciprocity meeting, we had Dr. Arthur B. Haskins, Assistant County Physician and a former President of the Hudson County Medical Society. His talk gave us much information of the workings of the State, County and Municipal Institutions. We had our usual "Scrap Book Day" and the members contributed a varied program, including much interesting information concerning *state medicine.* Hygeia has been stressed at all meetings and our new Chairman on Hygeia canvassed the whole Auxiliary membership, interesting many of the members in getting their husbands to subscribe to Hygeia, when they paid their dues in.

We have given subscriptions to Hygeia to 6 of our County Hospitals and we gave a subscription to Hygeia as one of the prizes at our January card party. We have given $25 to Y. W. C. A. and $25 to the Allied Drive. At our next luncheon, which will be our spring meeting, on June 13, $50 more will be donated to charity to make our usual quota of $100. We have a charity box at our meetings and members are asked to drop in a bit of change to give to the Visiting Nurse Association for emergency fund. How much this will be, I cannot say, but last year it amounted to $25.

During this year of depression and unrest, we have carried on with courage and determination and have done what we could to make life happier and easier both for our members and for those less fortunate.

"If we can aid in time of need
Or sympathize in sorrow,
Or make a weary sufferer think
About a brighter morrow,
If we can dry a fallen tear
Or lighten an hour of pain
Or help another his burden bear
We have not lived in vain."

Mercer. Our first meeting was a social gathering—a "luncheon and bridge"—to get to know each other. We felt that was very valuable because we had some new members and we got to know them much better. In January we were hosts to the State and although we had our annual "bad day" we were very glad to have some people out. We had a reciprocity meeting and Mrs. Lippincott was with us, but Dr. Iron, head of the State Children's Welfare, couldn't be with us, so he sent his Secretary and she was very interesting. The Parent-Teacher's Association was with us at this meeting. We had our spring meeting at the State School for the Deaf where we made a tour of the buildings, and had our business meeting and also a social time. We have just had a benefit card party—the first that we have ever undertaken. The proceeds of this party are to go toward the Widows and Orphans Relief Fund.

Monmouth. Our first meeting was held at the home of the President, in Long Branch. Plans for the coming year were discussed. The second meeting was a luncheon at the home with Mrs. Robert Watkins, of Belmar, the guest speaker of the afternoon. She gave a very interesting talk on the cooperation of the Auxiliary to the physicians. Dr. Watkins, President of the Monmouth County Medical Society, spoke to us regarding Widows and Orphans Relief Fund. Our third meeting was in Asbury Park. Mrs. A. Haines Lippincott talked to us on the subject of "Public Relations". It was very interesting and a large group attended. We feel that we have had an unusually successful year and that our membership has increased double and a great interest has been shown by the women of the entire county. We are very happy to learn that we won the prize.

Passaic. In October we had a short business session and bridge and welcome to our new members. In March Dr. Burne, Director of Public Nursing, was our speaker. At our May meeting for the election of officers, and reports of committees, we had the State President, Mrs. Adams, and the State Auxiliary's Recording Secretary as our guests. At our reciprocity meeting, in October, Mrs. Broadcote, of John Hopkins, lectured on "Protection of Women Against Cancer". We had an audience of over 200 women and the address was published in the March 1933 New Jersey Medical Society Journal. Our membership drive was the outstanding work of our County for the year, having added 27 new members. This brings our total to 113, of eligible membership of 225, or 50%. We have given 6 Hygeia subscriptions to libraries and Y. M. C. A.'s, etc. We have made contributions to charity, and our Auxiliary has been represented at State meetings.

Somerset. The Auxiliary to the Somerset County Medical Society held its first meeting of the year in October as guests of the Medical Society at the Annual Meeting. Five new members were secured

for the Society for the Relief of Widows and Orphans. At our last meeting, the Parent-Teacher's Association and neighboring women's clubs were invited. This is a rural community and we have not many physicians and so are not very active, but we enjoy the "getting together" and the Auxiliary work.

Union. We had 64 league meetings during the past year. Most of these have been held in the homes of members of the Auxiliary instead of having them in the Nurses' Homes. Our programs for the year have been given by the Auxiliary members themselves, instead of having outside speakers. Mrs. Orton has had charge of the programs for the year and has always had something of interest for us and an unusual feature for each meeting. We have had 3 annual meetings during the year. The first was in October. Then it was decided to change to January to coincide with the Treasurer's account and finally again in April. At the request of the State Auxiliary so that the annual meetings of the State and County Auxiliary would be at the same time, from now on we are only trying to have our one annual meeting a year. We gave a card party on November 16 at Mrs. Overseer's home, at which we raised $72.25, which went toward our Hygeia fund. Part was sent to subscriptions to Hygeia. We have purchased 2 of the Auxiliary hand books for the use of the Executive Board. We have had 60 members this year, one member resigned and we have 4 new ones.

Mrs. Dan Renner, Corresponding Secretary, announced that the Handbook for County Presidents, which was prepared by the National Organization, can be bought for 40 cents, and urged the new Presidents to procure a copy of same. Mrs. A. Haines Lippincott commended this administration on sending out these instructions to the County Presidents.

Report of the Nominating Committee

President, Mrs. Harry Hubbard, Plainfield

President-Elect, Mrs. A. J. Casselman, Camden

First Vice-President, Mrs. Dan S. Renner, Skillman

Second Vice-President, Mrs. George A. Rogers, Newark

Third Vice-President, Mrs. William Freile, Jersey City

Recording Secretary, Mrs. W. H. Gillium, Asbury Park

Treasurer, Mrs. Edward W. Clarke, W. Englewood

Directors: Mrs. Charles B. Russell, Montclair, has filled an unexpired term, and now takes the 3-year term of Passaic County. Mrs. William K. Campbell (3 years, from Monmouth County). Mrs. H. D. Corbusier (2 years, from Union County to fill the unexpired term of Mrs. W. H. Pratt, who resigned).

On motion, the Report of the Nominating Committee was accepted.

Since there were no nominations from the floor, it was moved and seconded that the Secretary cast the ballot. The above named officers were elected.

The next order of business was the President's Report. Mrs. Adams turned the chair over to the First Vice-President, Mrs. Campbell.

President's Report

Mrs. Adams: When I was inducted into office as your President a year ago, it was with a well defined idea of the work to be done. Unfortunately, my efforts together with unseen circumstances, have fallen far below my ideal. Three lines at that time seemed most important to me; first, increased membership. That has been accomplished by the hard work of the individual units. This is quite remarkable as it is the only organization that I have heard of that has not lost members during this year. As one of the objects is to promote fellowship among physicians' families I feel that we have done well. Second in value to me was to assist the State Welfare Board in their children's health program, as our future citizens must be healthy to be good citizens. Unfortunately, this program was not completed until too late for us to include it in our work. So, with all the other women of the State, we have helped in welfare work and Red Cross. I might suggest that child welfare work be taken up this year.

The third important work which seemed necessary to me was to increase the membership in the Widows and Orphans Fund that has been approved by the A. M. A., but it has been very difficult to make progress there. Under present conditions, members of the medical profession, who in former times would have paid a small amount, were they called on, have not been able to do so. Mrs. Orton has worked hard and done well. I hope as times continue to improve this work will gain rapidly.

We have been given many opportunities with the State Federation with whom we are now federated for fine work. I hope you will keep that in mind. Their classes will be well worth your time to look into and attend as many as you can. There are many contacts, such as gardens, drama, music, plays, poetry and prose. Look up these contests and enter them. They are interesting and will also bring before the public the fact that physicians' wives not only are voices on the telephone but are clever women and wide awake. I have enjoyed contact with you all on my visits to the different units. I would suggest you invite your State President to visit your unit once a year. You will receive inspiration

from her and she from you. She is going to the National meeting and will be full of good news and will hand it to you. She will be full of suggestions as to the work to be done and you will be able to show her that you are ready and anxious to do it. If your President resides in your neighborhood and is a member of your unit, remember that her position calls for respect and recognition. She should always have some part in the meeting, if only to be presented to the gathering or to introduce your speaker. This is due your President. If you accept a position in the unit or on the Board, vow that you will do the work well and promptly. Put a sign over your desk—"do it now". Elect your Delegates and Alternates and impress upon them that the State needs them at the meeting to inspire and help there. I would advise you all to make a study of the National Handbook for Auxiliaries. The help you will receive from it will pay you for any amount of time you use. It would be a good idea for you to devote one meeting a year to this. All duties of Chairmen are well mapped out and you can hardly go wrong with your work. I thank my Board for its efficient work. It has been necessary for me to call for much help. It has always been given promptly and pleasantly. Several Chairmen were forced to resign. Their places have been filled and hard work done by those who came in late in the year. Again I thank you all for your kindness and consideration. I now introduce my successor, Mrs. Hubbard.

Address of Incoming President

Mrs. Hubbard: First, I want to thank you for the honor you have bestowed upon me and assure you that my ambition is to make this a bigger and better Auxiliary year, to do some real constructive work to advance medical work in our State. Of the many lines of work we might follow, I would mention the educational first. Why? Because if we are to do anything for medical work we must first educate ourselves that we can more effectively help educate the public as to the value of true reliable medical work. The need for self-education is shown in the fact that the Auxiliary members are studying the fundamentals of individual and public health in increasing numbers all over the country. How can we do it? By following the plans approved by the American Medical Association Auxiliary. If it is approved by the New Jersey State Advisory Board to do this, we should hold a meeting of your President with the Chairman of the Program Committee, Chairman of the Public Relations Committee, members of the Advisory Councils with State Medical Society and a member of the State Board of Health to work out a program in which all can cooperate. And the Council can follow the same plan. We can help and advise the counties to plan their programs from the material prepared by the State Medical Society, the American Medical Association, the National Auxiliary, the State Health Department, and from outlines prepared by themselves under the guidance of the men of their own medical society.

As to how to educate the public, the County Auxiliary can conduct a series of educational talks and obtain speakers for other groups, such as the Parent-Teacher's Associations and Women's Clubs, cover all the schools in the County with Hygeia, which costs very little in the group subscriptions.

Have card parties or other benefits to raise the funds. It is the easiest and quickest way to put the true health before the people and it has the authority of the American Medical Association behind it. I speak with experience as I have served on the Hygeia Committee and I find that it is practically the best way to assist in this work.

One way in which you might reach the other organizations is to hold a tea and invite their officers and members for a health program with forceful speakers. Without numbers, we cannot do so much, so a membership drive is important and although we have gained in membership 127 this year, but 14 counties are organized. Your President will offer a prize as before for the best membership increase in the counties this coming year. The State Chairman of the membership will help you to organize and your President and other officers will be glad to do so also. If you cannot find new officers, keep the old ones serving until you do. Meet frequently, friendship justifies your existence. We may be called upon to help this year in school examination work, child health, periodic health examination, the question of *state medicine,* as well as regarding osteopaths and chiropractors. We have been asked to help the Widows and Orphans Fund and should carry it on. We might have parties or other benefits to raise funds for it. The Cost of Medical Care is another question we may be asked to work on. If so, let us be ready.

The list of books sent out by Mrs. McLaughlin of the American Medical Association Auxiliary should be studied. The county might buy these books and pass them around among their members as a lending library.

Our retiring President has suggested that one year is a short time in which to get into the work effectively as President or in any other office, and that our Secretaries be supplied with the forms and books suggested and approved by the American Medical Association Auxiliary.

Above all, I ask you each to be ready when called upon to do your best. None of us can guarantee perfect work and all we can do is the best we can do with the time at our disposal and the strength at our disposal, so say "Yes" when asked to serve as an officer or chairman or committee member. To rise to the top, you must first get to the bottom of things.

I would like to here announce that at 3 p. m. following the luncheon, I would like to have an organization meeting of the new officers and chairmen of the committees in this room. We will try to have it, promptly at 3 p. m. as many of us have to leave early for other appointments.

Committee Chairmen Appointed

Mrs. Hubbard then read the list of Committee Chairmen as follows:

Publicity and Report to State Journal, Mrs. James North, Atlantic.
Program, Mrs. A. Dunbar Hutchinson, of Mercer.
Public Health, Mrs. Don Epler, Essex.
Entertainment, Mrs. Salasin, Atlantic.
Credentials, Mrs. Mason, Atlantic.
Public Relations, Mrs. Schultz, Passaic.
Legislation, Mrs. McGuire, Mercer.
Hygeia, Mrs. McConaghy.
Organization and Membership, Mrs. Snavely, Essex.
Historian, Mrs. Cosgrove, Hudson.
Insurance, Mrs. Theodore Teimer, Essex.
Resolutions, Mrs. David Bentley, Camden.

Report of Pin Committee

Mrs. Van Ness gave a report of the *Pin Committee*. She reported for Mrs. Casselman, stating that the pins were designed last year but have not been obtained from Bailey, Banks and Biddle's as yet, but that your President will be notified when the pin has been accepted. It will probably cost $5.

Mrs. A. Haines Lippincott reported that the new Committee on *Hobby and Arts* has an exhibit in the Derbyshire Room, presided over by Dr. Campbell, of Long Branch. It is the first time that this has been held, and for the first year, it is felt that the work is very credible. The attention of the Auxiliary was called to the exhibition of the work of Mrs. W. Wayne Babcock's children.

Mrs. North: May I say now that Dr. Campbell asked that we say a few of the artists are exhibiting works in the Derbyshire Room. They are going to discuss their exhibits and arts between 4:30 and 5 p. m. and he asked that we all attend.

Treasurer Clarke asked what the opinion of the Auxiliary is about dropping unpaid members. This matter was discussed in one of the Executive Board meetings, and it was the consensus of opinion that the members be dropped if they have unpaid dues for 2 years and the opinion of this Annual Meeting is desired. Mrs. Campbell moved that the matter pertaining to delinquent members of the County be left to the discretion of the County. Motion seconded and carried.

Mrs. Lippincott suggested that it be one of the projects of this organization next year to organize unorganized counties. Also, she called attention of the Auxiliary to Public Relations work. She recommended that the County units retain their Public Relations Chairmen indefinitely.

It was moved and seconded that a rising vote of thanks be given to our former President, Mrs. Adams, for her work and coöperation and the pleasure derived by everyone from that contact.

There being no further business, it was moved and seconded that the meeting adjourn. Meeting adjourned at 12.15 p. m.

MEETINGS OF THE COUNTY SOCIETIES

Atlantic County.—Meets second Friday evening monthly, except in June, July, August and September. Annual Meeting in November.

Bergen County.—Meets on second Tuesday each month, except July and August. Annual Meeting in January.

Burlington County.—Meets second Wednesday afternoon of January, March, May, September and November. Annual Meeting in November.

Camden County.—Meets first Tuesday in each month October to May inclusive, with an outing on second Tuesday in June. Annual Meeting in October.

Cape May County.—Meets on first Tuesday in April and October. Annual Meeting in October.

Cumberland County.—Meets on the second Tuesday of January, April, July and October. Annual Meeting in October.

Essex County.—Annual Meeting is the first Thursday in October. Other meetings on the second Thursday of each month, November to May, inclusive, on call of the President.

Gloucester County.—Regular meetings on the third Thursday of each month, October to June, inclusive. Annual Meeting in November. Annual Social Session in September.

Hudson County.—Meets first Tuesday evening of each month, October to May, inclusive. Annual Meeting in October.

Hunterdon County.—Meets on the fourth Tuesday of January, April, July and October, the latter being the Annual Meeting.

Mercer County.—Meets on the second Wednesday of each month, except July, August and September, at 8.30 p. m., in the Carteret Club at Trenton. Annual Meeting in December. Annual Banquet in November.

Middlesex County.—Meets on the third Wednesday afternoon of each month, September to June inclusive. Annual Meeting in December.

Monmouth County.—Meets on the last Wednesday in each month from October to June inclusive. Annual Meeting on the Tuesday after the first Monday in December.

Morris County.—Meets on the second Tuesday in March, June, September and December. Annual Meeting in September. Special meetings (1-3 yearly) for additional scientific discussions arranged by Executive Committee.

Ocean County.—Meets in May and November as called by the Secretary. Annual Meeting in November.

Passaic County.—Meets on the second Thursday evening of each month, except June, July and August. Annual Meeting in October.

Salem County.—Meets on the second Wednesday in February, April, October and December. Annual Meeting in October. Social Meeting in May.

Somerset County.—Meets on the second Thursday afternoon in February, April, June, October and December. Annual Meeting in October.

Sussex County.—Annual Meeting on the second Tuesday in September; other meetings bimonthly, September to May inclusive.

Union County.—Meets on the second Wednesday of January, April, July and October. Annual Meeting in October.

Warren County.—Meets on third Tuesday of January, April, July and October; the last named being the Annual Meeting.

THE JOURNAL

OF THE

Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION

OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange New Jersey, under Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

THE N.Y. ACADEMY OF MEDICINE
OCT 17 1933
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Vol. XXX., No. 10 Orange, N. J., October, 1933 Subscription, $3.00 Per Year Single Copies, 30 Cents

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For Enteritis

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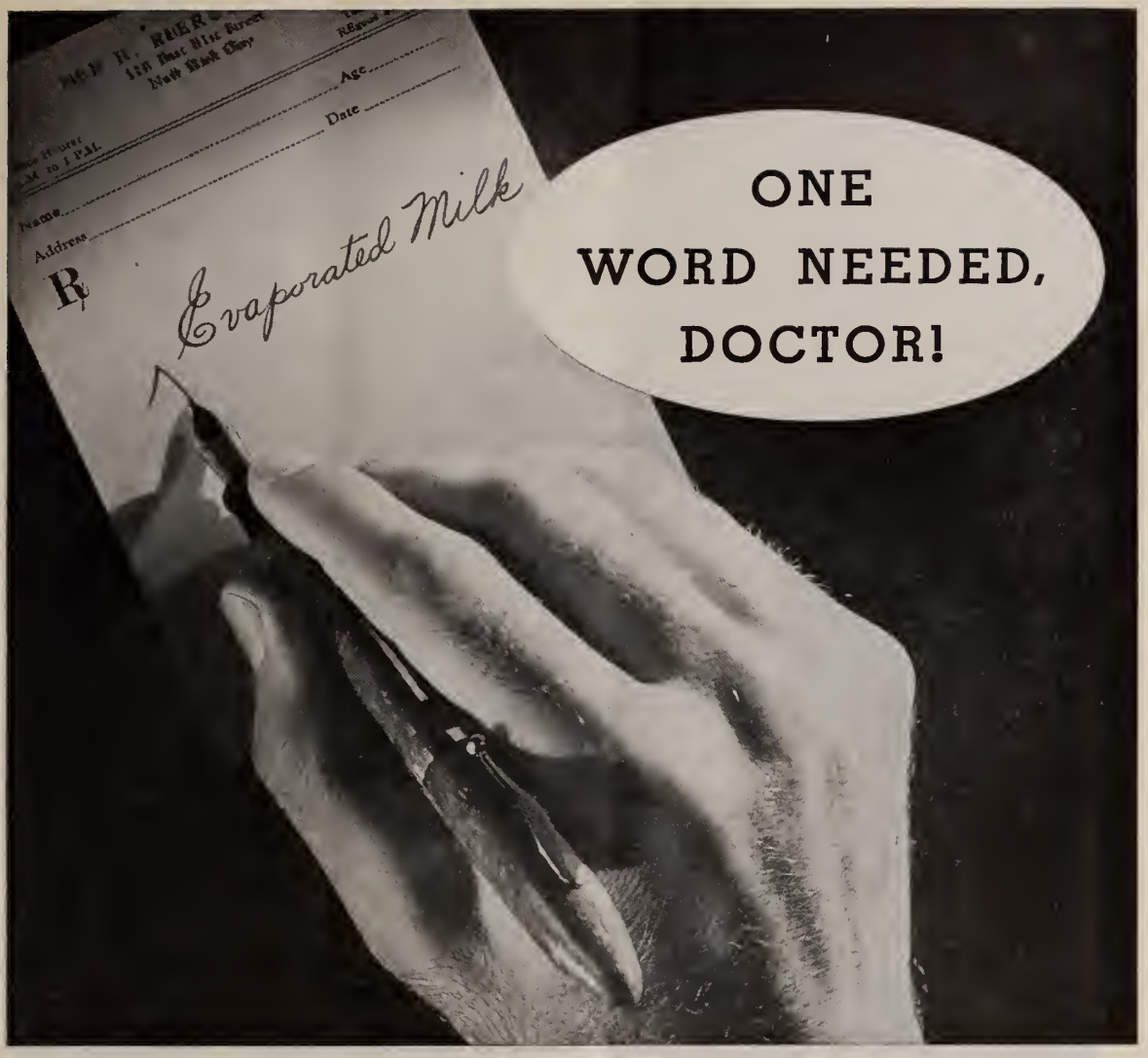
From this angle, the recent introduction of the pre-cooked form of Mead's Cereal, known as Pablum, assumes new importance in the doctor's psychological handling of both mother and child, quite aside from its nutritional value.*

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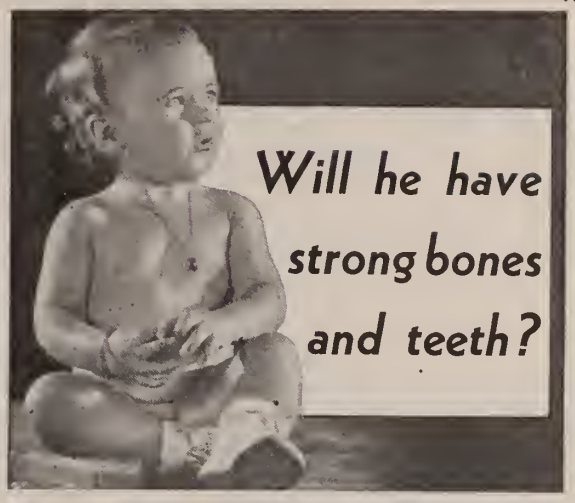
MEDICAL GROUP HONORS EAGLETON

(Newark Evening News, Sept. 23)

Dr. Wells P. Eagleton was made President-Elect of The American Academy of Ophthalmology and Otolaryngology at its Thirty-eighth Annual Meeting in Boston, the week of September 17. No Jerseyman ever has received a similar honor. Dr. John Wheeler, of the New York Medical Center, was elected President for this year.

Dr. Eagleton is Chairman of the Board of Trustees of the New Jersey State Medical Society, Medical Director of the Newark Eye and Ear Infirmary, Chief of the Division of Cranial Surgery at City Hospital and a Trustee of Newark Museum and the Welfare Federation of Newark.

The Academy of Ophthalmology and Otolaryngology is the largest society of specialists in the world. It has a membership of more than 2200. The Academy was the first to start postgraduate instruction and this has spread all over the United States and into Canada.



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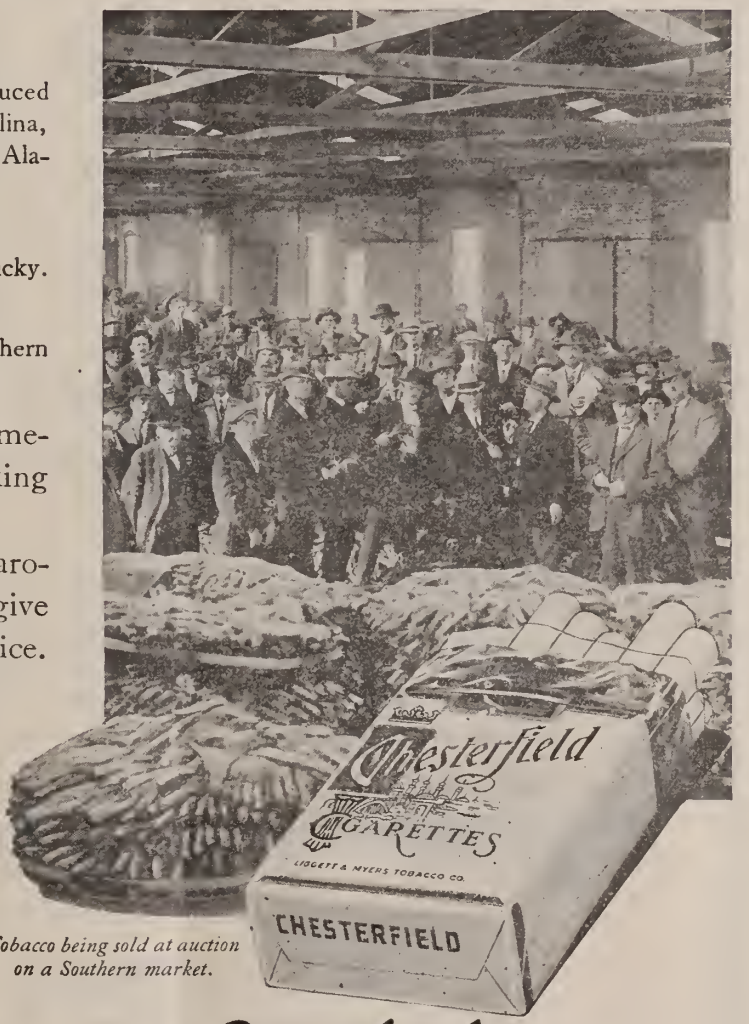
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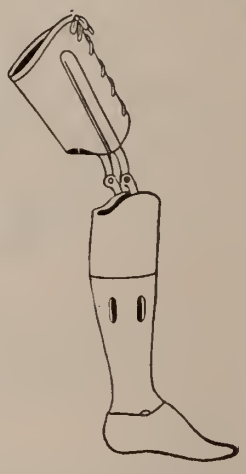
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Vol. XXX., No. 10 ORANGE, N. J., OCTOBER, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

Editorials

THE MEDICAL RELIEF PLAN

The Medical Society of New Jersey has entered into an epoch-making agreement with the State Emergency Relief Administration for the care of the relief clients or patients.

In adopting this plan, the profession is making a real contribution to the State for the better care of the poor. It is also providing for a renaissance of the proper ethics of practice in a way that insures part-payment to the physicians. Furthermore, it is being clearly shown that it is a more economical method for the community.

We took a necessary and timely step. Our methods for the medical care of the poor have been cracking badly under the overwhelming loads of the past few years. The poor were not receiving adequate medical care. The doctors were not receiving sufficient income from their total practice to help them carry the extra burden of the poor.

Many evils have developed in our system for the care of the indigent. "Mass practice", or the loss of the personal relationship between the patient and physician, has been a most unfortunate trend. To a large degree, free clinics and dispensaries as at present organized are unwholesome and degrading. We have had too much of the "city physician" practice. So we were faced with the alternatives of more so-called city physicians and new clinics to be opened by the State or to develop our present plan.

In this scheme, sponsored alike by the State Emergency Relief Administration and the Medical Society of New Jersey, we have preserved the free choice of physician, the personal call at the office or in the home and we have assured the physicians of part-payment fees.

Proof of the wholesomeness of this plan comes from unexpected sources. The Federal Emergency Relief Administration has recently issued Rules and Regulations No. 7. This governs medical care provided in the home of recipients of unemployment relief. A careful perusal of these orders does not reveal any contradictions of our plan. In fact, we may easily believe that the Federal regulations were copied from those of New Jersey.

Of necessity there must be some red-tape; orders to be signed by the patients, the nuisance of presenting bills on the first of the month, and delays in payment. Furthermore, it will take some time before the officials of all the municipalities can become fully acquainted with the plan.

Physicians, we hope, will accept the relief medical orders in the proper spirit. Unnecessary calls and treatments are to be avoided. Patients are not to be sent to hospitals if they can be cared for at home. If hospital care is necessary, the relief office should be notified in advance except when the emergency is too great.

Upon the County Medical Committee falls a large responsibility. They must organize the work of their county in coöperation with the County Director. They must protect the physicians. But they must also discipline them,

for they have the power to remove a physician from the approved list. The committee is also vested with the power to settle disputes in conjunction with the County Relief Director.

This plan for the medical relief of the poor is not perfect. Readjustments and extensions or retractions will doubtless have to be made as experience directs. But we are convinced that its basic principles are correct. Therefore, we can well afford to work patiently and wholeheartedly to make it a success.

Spencer T. Snedector, M.D.,
Chairman Medical Relief Committee,
Medical Society of New Jersey.

A Letter from Mississippi

The New Jersey plan is attracting attention from many parts of the country. The following letter, coming from Mississippi, is indicative of the interest being taken in this project:

Riley Burnett, M.D.,
Gay Building,
Biloxi, Mississippi
September 19, 1933

Dr. Charles H. Schlichter,
Elizabeth, N. J.

Dear Doctor: I notice in Medical News of A. M. A. Journal of the adoption of a Medical Relief Policy by the Medical Society of New Jersey in coöperation with New Jersey State Emergency Relief Administration.

If not asking too much, will you kindly send me an outline of your plan or program if such has been completed? Thanking you very kindly for this courtesy, I am,

Yours very truly,
Riley Burnett, Act. Sec.,
Harrison-Jackson, Stone-Hancock Med. Society.

Dr. Schlichter's Reply

Sept. 25, 1933

Dr. Riley Burnett,
Gay Building,
Biloxi, Mississippi.

Dear Dr. Burnett: I beg to acknowledge receipt of your letter of September 19th.

In the early Spring, during the month of March, the New Jersey State Emergency Relief Administration approached the medical profession of the State through the New Jersey State Medical Society and offered to compensate the doctors for work done among those receiving emergency relief from the State, as well as those persons who were unable to pay for medical service; that is, those who were able to provide food and shelter for themselves but were unable to provide medical care. A copy of this letter addressed to Dr. Lippincott, President of the Medical Society of New Jersey, is marked "A" and is enclosed herewith.

The matter was referred to the Welfare Committee of the New Jersey State Medical Society and a committee was appointed to meet the representatives of the New Jersey State Emergency Relief Administration and draw up a suitable form of agreement for the working out of this plan. This committee consisted of the Chairman of the State Welfare Committee, the Chairman of the Board of Trustees, the Secretary of the State Medical Society, one member of the Board of Trustees of the State Medical Society and the Councilors of the 5 Councilor Districts of the State Medical Society. After a number of meetings, an agreement was finally arrived at which was satisfactory to both sides. The State Emergency Relief Administration was prompted to make this offer to the medical men of New Jersey because it realized that the doctors were carrying an enormous load by caring for a large number of people who were unable to pay. In other words, they were doing a large amount of charity far beyond the usual amount that our profession has always gladly and willingly done.

The State Emergency Relief Administration further wanted to keep the people in personal relation with their family physician and to keep them from becoming charity-minded or from developing the free clinic, free hospital and charitable medical service habit.

At a meeting held in May, a preamble and resolutions were sent to the State Emergency Relief Administration, a copy of which, marked "B" is enclosed herewith. This was the basis for the negotiations. You will notice in that preamble that several broad proposi-

tions were stressed and, on the whole, these were accepted by the State Emergency Relief Administration. A sketch of the plan of organization was also drawn up and finally embodied in the agreement, marked "C". The agreement was then drawn up and a letter sent out to the Presidents and Secretaries of the various County Medical Societies, copy of which, marked "D", is also enclosed. The entire agreement was submitted to each of the 21 County Societies for their approval and, with slight modifications to fit the fee basis of each County, some of which are rural and have a lower fee basis, it was adopted by all. This agreement, marked "E", is also enclosed.

The plan has been in operation in some of our Counties for a period of several months and is working very nicely. Doctors are being paid for the work they are doing and, through the watchfulness of the County Societies, politics have been kept out; that is, when the patient who applies for relief comes to the Relief Administration, the first question he is asked is, "Who is your family doctor?" If he replies that he has one, well and good. The order is made out to that doctor. If he says he has no family doctor, he is then asked who last attended him or his family. Replying in the negative, he is then handed a list of physicians who have signified a willingness to coöperate in the plan and told to make his choice from among them and to present the order given to that doctor. In this way the work is distributed where it really belongs, to those who are and have been taking care of their unfortunate patients, and it makes it impossible to give all, or a greater part of the work, to a politically favored few.

Should you care to get more information from the State Emergency Relief Administration, write to Col. Joseph H. Bigley, State Manager, Department of Standards and Research of the New Jersey State Emergency Relief Administration, 540 Broad Street, Newark, N. J. Col. Bigley was a great help to the medical profession in the organization of this work and is continuing his interest in it.

I have just received from the Federal Relief Administration at Washington, D. C., the "Rules and Regulations No. 7 Governing Medical Care Provided in the Home to Recipients of Employment Relief". I have not as yet had time to read it, but in skimming it over I find it is practically the same plan which we originated. It might be well to send for it.

I trust that the enclosed matter may be of use to you. If there is any way in which we can help you, kindly call on us and we will do all we can to be of assistance. We believe the plan to be fair to the State, fair to the Medical Profession and to the patients, inasmuch as it gives the patient the right to a choice of a physician and it keeps the relation between the family physician and the patient intact.

Very truly yours,

Charles H. Schlichter.

THE PLAN

Preamble

In accepting this opportunity to coöperate with the E. R. A., the medical profession acknowledges its responsibility first and foremost to provide the best possible medical care to the indigent poor of New Jersey; and, secondly, to the profession itself to promote and safeguard its interests.

Several broad principles may be enumerated:

(1) The medical society enters into this plan for the period of the emergency only and it shall have the power to designate when the emergency is over.

(2) The control of the administration of the medical relief shall reside with the society through its designated State and county committees.

(3) The present and future policies shall be subject to the approval of the society.

(4) The preservation of the personal relationship between the doctor and patient shall be paramount.

(5) The fee schedule in general shall be on a basis of about 2/3 the customary fees.

(6) The payment of fees shall be arranged on as simple and easy a basis as possible to facilitate collection by the doctors.

(7) It shall be agreed that medical relief shall be supplied by the individual physicians, preferably by the patient's own or previous physician and shall insure free choice of physician by the client.

(8) Clinics shall not be formed except as

approved by the Medical Relief Committee of the State.

(9) It shall not be the policy to develop and centralize medical care in the hospitals or clinics except in so far as special diagnostic and treatment aids are needed.

(10) The E. R. A. shall not pay physicians for work in clinics; nor shall it pay hospitals for admission clinic charges.

(11) It shall not be the policy of the E. R. A. to substitute midwives for physicians in obstetric cases.

(12) Problems will arise in some counties requiring special recognition and treatment.

It is recognized that there are grave dangers inherent in this plan, such as the development of a bureaucracy both in the medical organization and the E. R. A.; that favoritism to certain physicians may develop; that unethical practices must be watched.

The designation of who shall receive medical relief as provided by the E. R. A. is primarily for the E. R. A. to decide. However, the Medical Relief Committee of the State may make suggestions.

That the medical society enter into this plan for 1 year or for the emergency only.

Organization

The organization of Medical Relief shall be as follows:

A Medical Relief Committee to be known as the Medical Relief Committee of the State Society shall be organized and assigned the following duties:

(1) To formulate policies and plans in cooperation with the E. R. A.

(2) To carry on a close liaison with the E. R. A.

(3) To organize a sub-committee in each county to be known as the Medical Relief Committee of the County.

(4) To act on all complaints or requests from either the E. R. A. or the county committees.

(5) To gather as accurate reports as possible of the work in each county.

(6) The district councilor on the committee shall act as organizer and supervisor of the work in the counties in his district.

Medical Relief Committee of the County

(1) Shall be appointed in each county.

(2) Shall organize to supervise the work in each county in coöperation with the County Relief Administration.

(3) Shall maintain at all times direct control over the Medical Relief.

(4) Shall have power of approval or adjustment of bills, such as those objected to by the E. R. A. as being exorbitant, false or technically incorrect.

(5) Shall have frequent contact with the E. R. A.

(6) Shall secure monthly reports of the amount of work done, bills presented, bills paid, doctors receiving payments and amounts, and any other pertinent information.

(7) Shall be zealous to provide the best medical care—coöperate with the other health organizations, particularly nurses.

Note to the Officers of the County Societies

To the Presidents and Secretaries of the County Medical Societies:

The Medical Relief Committee of the State Society submits herewith a memorandum of an agreement entered into with the State Emergency Relief Administration which outlines the practices to be observed in taking care of Emergency Relief clients.

In reading this plan you will observe that we have agreed to set up in each county a Medical Committee to be known as the Medical Relief Advisory Committee of the county to coöperate with the County Director in order that the principles set forth in this plan may be started into operation.

The Committee, therefore, requests you to take the following immediate steps:

(1) The County Society shall appoint or elect a committee of not less than 5 members to be known as the County Medical Relief Advisory Committee.

(2) This committee shall immediately prepare for submission to the County Director a list of licensed physicians within the county who are willing to accept Emergency Relief cases.

(3) The committee shall contact the County Director of Emergency Relief at once to arrange a fee schedule for the Emergency Relief clients.

(4) While the maximum fees of $1 for an office call, $2 for a house visit, and $25 for an obstetric case have been agreed upon; the rate for your individual county shall be based upon a proportion of from 1/2 to 2/3 of the prevailing average fees in your county.

Several parts of the plan are worthy of special attention:

The doctors shall strive to take care of the clients in the home and shall only refer them to the hospital for emergency conditions.

The method of submitting bills should be carefully studied and it should be noted that no cases shall be charged to the Emergency Relief Administration unless properly authorized.

It will be necessary to inform every member of your society about the details of the plan and it will be published in the next issue of the State Journal. (See Aug. 1933 Journal, pages 591-593).

The committee stands ready to assist in any way possible to help in organizing or to smooth out troubles which may arise. We have promised the Emergency Relief Administration the wholehearted coöperation of the profession.

Respectfully submitted,

Spencer T. Snedecor,
Chairman Medical Relief Committee
of Medical Society of New Jersey.
James Fisher, Secretary.

Committee Members

F. S. Quigley, President.
J. B. Morrison, Secretary.
W. P. Eagleton, Chairman Board of Trustees.
C. H. Schlichter, Chairman Welfare Committee.
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Economics

PHYSICIAN'S CONCERN IN CHANGING ECONOMIC CONDITIONS

We need make neither apology for nor explanation of our having devoted all of our editorial space in recent issues of the Journal to the general subject of *economics,* for that subject has been uppermost in the minds of all physicians during the past year or more and bids fair to remain so for an indefinite period of time, but we find now that even such space as has been thus used is not sufficient to embrace all of the good things we would like to lay before our readers while they are giving this subject careful consideration. So, with an exceptionally interesting article before us, which we would like to pass along immediately, yet being unwilling to break into a previously announced editorial plan or to postpone the promised personal discussion of Dr. Hartwell's contribution to the Economic Symposium", we are resorting to this means of presenting you with that special material.

Dr. William H. Mayer, of Pittsburgh, in his "Presidential Address" to the Medical Society of Pennsylvania (Pennsylvania Med. Jour., 35:1, Oct. 1931), included this topic among those upon which he was reporting the observations of a State Society President. Dr. Mayer was, and is, however, more than such a President, and had we no further knowledge of the man than is obtainable by the reading of his Address, we would classify him as an intelligent, educated, cultured, far-seeing and wise physician, especially fitted for the kind of *leadership* our Country, State, and National Medical Societies need today.

From that portion of his remarks dealing with the various attempts to socialize the practice of medicine (to establish *state medicine*) we have abstracted the following:

It is an anomalous situation that a group of scientifically trained citizens, whose history time and again reveals the success of individual effort and individual urge, should be relieved of leadership where they alone are equipped to lead. It is hazardous indeed to add to the cost of sickness the expensive political machinery which is always required to administer such a governmental agency. The economic losses through illness and its cost, aside from compensation of physicians, are practically

fixed sums. Each plan now in force is based largely on reducing only that which provides the income of the physician. It has been shown by accurate study that the actual cost of illness, aside from the individual economic loss, is so distributed that only one quarter of the cost of the management of sickness is attributed to physicians' fees. This item is approximately ¾ of 1% of the total income of the citizens of the United States. It is perfectly evident that to attack this cost is rather a futile economic gesture. Were this all to be considered, it would be serious enough, but the widespread effect of such a procedure is fraught with danger to our nation. We cannot view such a possible consequence except with alarm. This is not time for intolerance, for we, more than anyone else, are aware of the devastating cost which sickness leaves in its wake. Without a full concept of medical practice from the point of view of the physician, it is not difficult to see how the sociologist is inclined to accept the time-honored contribution of a great profession as an asset which will not be disturbed by adoption of the recommendations of the sociologist who expects the same medical service which has been steadily improving through the centuries to continue. The education and the professional equipment of the physician, however, are now more expensive than the totals upon which estimates of a few years ago were based. The economic status of the practitioner of medicine is of necessity changed. He can no longer be expected to practice his art or progress in medical science under conditions of the past. With the growth of medical science and its increasing efficiency, and its increasing complexity, an increased expense is to be expected. It will be only necessary that the public and the well meaning sociologists be enlightened as to the tragic circumstance which would inevitably result with the destruction of that which the legitimate practice of medicine has builded.

By reason of our traditions, we are pledged to a greater service than that required for the present generation. It falls to us as mentors of health to enlighten and direct public opinion to appreciate our mission.

The individual has a right to insure himself against sickness, but the plan on which such insurance is accomplished must be formulated by those whose experience and knowledge of the sickness problem fit them with perspective. We are equipped to do this, for our ranks contain those whose talents and experience may be relied upon to bring about the type of solution which is consistent with the sane evolution of human progress. We have directed our energies toward furthering public health legislation, beneficial to mankind. We have increased and preserved standards of medical education and training. We have never been prompted by selfishness. We have proudly combated those with exaggerated commercial instincts who, through ignorance or iniquitous purpose to exploit the sick, have sought to legalize their activities. Had we not interposed ourselves, we should have been derelict in our duty to the State. We are proud of our achievements as the legitimate practitioners of medicine in this direction. Were we but materially minded, we might remain complacent in the knowledge of the inevitable failure of the pretender, but the proof of this failure could only be at the expense of human health and happiness. Hence we have conceived it our duty, and will so continue as citizens with special training, to advise those who make laws, that new legislation must not react to the detriment of human health. This the public should know and it should be systematically taught the truth of our unselfish position motive. It is not given to a materially-minded world to understand the height of the ideals which prompt our activities.

That the history of medicine and its wonderful contributions is too little known to our own members, is a painful truth. Our society meetings might well be devoted, at intervals, to a study of its glorious pages, with profit to all of us. Related to the public, such history can be of inestimable value in strengthening confidence and thereby adding to the comfort of our fellow citizens. There is nothing which will dispel the terror of threatening illness so much as a knowledge of the contributions of physicians to the well-being of mankind throughout the centuries. Our Public Relations Committee, conceived and constituted with this end in view, has consumed considerable time planning its activities, it being characteristic of our profession to be deliberate. The time has, however, arrived when we can no longer take for granted our success. *We must recognize the changing order of things just as we expect similar recognition on the part of the sociologist and the public.*

ORIGINAL ARTICLES

INJURIES OF THE INFANT DURING DELIVERY

P. Brooke Bland, M.D.,
Philadelphia, Pa.

In considering the problem of injury of the infant during labor, I can recall most lucidly my experience in the morbid anatomy room of the General Hospital in Vienna, many years ago. It was my good fortune to spend many hours with Dr. Störck, who had charge of the autopsy work. It was not uncommon to witness from 10 to 15 postmortems almost every day, and adult material for postmortem study was always abundant because all patients dying in the institution were subject to autopsy investigation.

Daily I observed large numbers of newly born babies in the morbid anatomy room, but in these, routine postmortem studies were not made. In surveying the large number of dead infants, I was led to speculate as to the cause of death. The question always arose in my mind whether all were inevitable or whether some, at least, were not preventable.

In recent years, the question of fetal injury, in relation to fetal death has been receiving more and more the long deferred attention it justly deserves. Obstetrics in general has made considerable progress in recent years, but the mortality associated with child bearing, both maternal and fetal, is entirely too high. Year in and year out the maternal death rate remains more or less constant, the figures ranging from 6 to 7 per 1000 live births. Apart from the immediate maternal mortality, it is impossible to compute the multitudes of women rendered physically incompetent or partially disabled by complications developing in pregnancy with its culmination in labor. There is, perhaps, no other normal function performed by the human body associated with greater morbidity and mortality.

Childbearing, as a cause of death, stands next to tuberculosis in women between the ages of 15 and 45. Human reproduction is usually defined as a physiologic process, but in many instances it assumes pathologic proportions. It might not be prudent to deal in prophecy, but it seems reasonably safe to assert that 50% or more of our maternity patients suffer with some type of physical disability.

Apart from the maternal morbidity and mortality, statistics disclose that from 3% to 5% of all babies die during delivery or shortly there-after. It is estimated that in our country the annual death rate of babies less than 1 year old—including still-births—totals 300,000; and it is generally conceded that 50% of these deaths, or 150,000, are unnecessary.

A report of the United States Department of Labor, Children's Bureau, shows that more than 42% of the babies dying under 1 year of age do not live to complete the first month of life. Of the 42% mentioned, 7% die as a result of ante-natal conditions, or from accident, or from injury sustained at the time of birth. Of the babies who live less than a week, 83% die of the causes mentioned. Of those who live less than a day, the conditions named are responsible in 94% of cases.

While statistics provide fairly reliable data respecting fetal death in its relation to pregnancy and parturition, statistics cannot compute, nor can the human mind fully comprehend, the vast army of infants left physically disorganized or mentally crippled; and here-in lies the grim tragedy of child-birth. Fortunately, in recent years this is receiving more and more attention. Ehrenfest says: "Wider interest in the causation and prevention of parturitional injuries of the infant, while of relatively recent date, is growing rapidly, and is obvious to anyone conversant with modern obstetric literature." Again: "Today we are facing the surprising fact that in at least 40% of the autopsies properly performed on still-born infants and those dying within the first

few days after birth, some sort of intracranial lesion is found."

A relatively high puerperal infant morbidity and infant mortality is not restricted to any nation on earth. In England, according to Holland, infant mortality has been reduced ½ in the past 22 years, or from 154 per 1000 in 1900 to 77 per 1000 in 1922. The number of deaths occurring in the first 4 weeks postpartum, however (neonatal mortality), has shown only a slight decline. Nearly 50% of the deaths "occurring" during the first year of life "occur" during the first month, and nearly half of these "occur" during the first week. It has been shown that the larger proportion of these are due to obstetric accidents or obstetric injuries.

An analysis of the possible injuries to which the infant is exposed during delivery discloses that damage may be inflicted anywhere from the cutaneous envelope to the mucous lining, including the area between the bony architecture and the parenchymatous organs. The most serious damage, both in its immediate and remote results, is that sustained by the cerebrospinal system. Schwartz, in a series of investigations on new-born infants, asserts that the pathologic conditions arising in the first month of neonatal life are dominated by injuries sustained by the brain during labor. Fischer, from postmortem studies, found that 10% of the deaths occurring during the first 4 weeks postpartum were the result of cerebral damage inflicted at the time of birth.

Passing now to the serious accidents and injuries of parturition, I shall briefly consider those affecting certain nerves, the spinal cord and the brain. To these special types of birth injury, considerable attention has been directed during the past few years.

Trauma, according to Von Reuss, results either from trouble in the genital passage of the mother, or from obstetric maneuvers, either manual or instrumental. In artificial deliveries, it is either manual manipulations in breech or transverse presentations (version with extraction) or the obstetric forceps which damage the child. In spontaneous delivery, the cause lies chiefly in disproportion between the child and the mother's pelvis, in pelvic deformities or in malpresentations.

Damage may occur particularly after too long labor and, also, in precipitate labor, in which the child is forcibly driven through the pelvic canal. While it is well to recall that almost all forms of injury may arise during spontaneous or normal birth, the larger proportion of injuries occur after difficult manual or instrumental delivery.

Accumulated evidence tends to disclose that conditions heretofore regarded as congenital are in reality late expressions of damage sustained during labor, conditions which in the beginning did not give rise to prominent symptoms and which were undetected because of indifferent care or lack of knowledge on the part of the obstetrician. The late recognition of many birth injuries may probably be attributed to the attendant, who regards his obligation as discharged when the umbilical cord is tied and dressed. We should not leave the patient with the assumption that our duty ceases with birth of the baby.

In order to afford every possible safeguard for the child, those born in our department in Jefferson Hospital are placed under the immediate care of a competent pediatrician. This ideal method is not practicable in general work, but it should constitute a routine feature of neonatal work in institutional practice.

Nerve injuries. Parturitional nerve injuries are limited almost exclusively to the facial and brachial plexus. These are nearly always the result of complicated labors, and usually of artificial deliveries.

E. Stransky analyzed 121 case records of birth palsies which he collected from the literature. In these, the type of delivery was as follows:

Manual assistance (extraction, freeing of arm)	50
Forceps	31
Protracted and difficult labor	27
Asphyxia	11
Spontaneous labor	2

While nerve injury may occur in all varieties of presentations, most authorities believe that the Duchenne-Erb type of palsy, which involves the fifth and sixth cervical nerves, is

found almost exclusively after breech presentations; but this still seems open to controversy.

Ehrenfest assigns direct pressure of a forceps blade as occasionally responsible. More frequently, he states, trauma inflicted in delivering the after-coming head is the causative factor. Respecting the mechanical factors as influential in obstetric paralysis, those upon which responsibility is usually placed, are: (1) direct compression, manual or instrumental; (2) traction resulting in over-stretching; (3) traction causing plain tearing; (4) compression or traction followed by blood extravasation or inflammatory disorganization.

Either of these destructive forces may follow the Prague or Mauriceau-Smellie-Veit method of breech extraction. Direct pressure by the tip of one blade of the obstetric forceps is said to be definitely causative in a certain number of cases, but this, according to Stolper (quoted by Von Reuss), is only possible when the forceps blades are applied to the head in oblique position, or when the rules of proper application are not observed, or deflection is overlooked.

In certain cases, serious nerve trauma has resulted from pressure of a hematoma, and even pressure of the umbilical cord may sometimes, though rarely, account for nerve damage in the region of the brachial assembly (Roulland).

Pressure of the clavicle on the brachial nerves is said to be a cause in some cases, especially if the arm locks over the head in vertex presentation; and Dr. Burr, of Philadelphia, in 1920, referred to trauma of the cord itself as sometimes causative.

A paper by Gilmour recently appeared, reporting 25 cases of brachial birth palsy, of which 23 were of the Duchenne-Erb variety; 2 were of the general arm variety; but there was no instance of a pure Klumpke type. As to the cause in these cases: All but 3 of the births were described as long or difficult, though in 1 case the period of labor was short, only lasting 5 or 6 hours. In 2, delivery was natural and unassisted. In the rest, chloroform was used to facilitate instrumental or manual delivery. Three infants were said to have been asphyxiated and to have required prolonged resuscitation. The presentation was vertex in 16 cases, breech in 4 cases and irregular in type in 5 cases.

Six forms of brachial plexus damage are described, according to the site and extent of the injury:

(1) The most common form is the Duchenne-Erb type, in which the upper part of the plexus is affected. The damage involves the fifth and sixth cervical roots, or the trunk formed by their union. Functional disturbance is observed in loss of power in the muscles about the scapula and arm, giving rise to the typical deformity in the arm, forearm and hand, described sometimes as the "tipping" attitude.

(2) Involvement of the eighth cervical and first thoracic nerves, or the trunk formed by their fusion, is usually described as Klumpke's type. Loss of function occurs in the muscles of the hand, and also in the large flexor muscles of the forearm. The second thoracic root is sometimes affected and, as a result, the muscles supplied by the musculospiral, the extensors of the hand and fingers, are also palsied. In addition, owing to the intimate relationship of the first thoracic to the sympathetic, changes in the oculopupillary reaction occur. Damage of the lower section of the plexus is followed by more extensive and serious paralytic disturbance than injury of the upper section.

(3) In certain instances the damage of the plexus is more or less complete, resulting in loss of power of all the muscles of both arm and forearm. In this type serious bone lesions, it is claimed, are usually an accompaniment of the primary damage. Primary subluxation of the humeral head has been pointed out as a cause by Thomas, of Philadelphia, and others.

(4) In certain other cases, there is a combination of the upper and lower types, with transition from partial to total paralysis.

(5) In still other instances, damage is more or less isolated, and palsy of a single muscle, such as the deltoid or supinator longus, occurs.

(6) The damage may involve both sides, resulting in a bilateral palsy, though this is extraordinarily rare.

Paralysis of the lower extremity. Damage of the cord or lower spinal roots, resulting in paralysis of the lower extremities, is exceedingly uncommon. Von Reuss refers to a case of complete paraplegia. It existed from birth and was not associated with loss of sphincter control, thus indicating an injury involving the spinal roots of the second and fourth lumbar and the first and second sacral segments. Injury was thought to be caused, in this case, by excessive traction during delivery.

Obstetric facial paralysis. From the obstetric standpoint, palsy of the muscles supplied by the seventh nerve falls into 2 groups: that following spontaneous labor, and that following manual or instrumental delivery. In the first group, injury is sustained only when there is frank disproportion between the diameters of the fetal head and maternal pelvis. The trouble is seen chiefly in various forms of contracted pelves, especially the flat pelvis, the head presenting transversely, with excessive cranial stress being directed from the sacral promontory, the symphysis, or an abnormal bony prominence. As a rule, the trouble arises after primary cephalic presentations, rarely after breech presentations.

The palsy may result: (1) from damage in the central origin (basal) of the nerve; (2) from injury of the cortical motor area; and (3) from damage of the peripheral portion of the nerve itself, especially that portion about or just beyond its emergence from the stylomastoid foramen, or of its branches. The palsy, therefore, may be the result of intra- or extra-cranial injury.

The third type of damage is by far the most common (this applies to the second group), resulting in most instances from direct pressure of a forceps blade. Some cases, probably a relatively large number, result from violent edema or a large blood collection following forceps trauma. At any rate, it is estimated that at least 10% of the facial birth palsies follow difficult forceps delivery, and only occasionally is palsy observed after spontaneous labor.

The incomplete nature of the paralysis, and the fact that in most instances the damage is not permanent, is explained on the basis, first, that severe compression is not made on the trunk itself, but on its branches, especially those coursing through the soft parotid gland; and, second, that damage of a temporary nature only is, therefore, sustained.

Von Reuss, whose work has been drawn upon constantly in the preparation of this paper, also directs attention to the temporary and incomplete nature of obstetric facial paralysis, and, owing to this feature of the disorder, he prefers the term "paresis" instead of "paralysis".

Intracranial injury of the nerve may be suspected if the characteristic signs of the facial palsy are associated with evidences of hypoglossal paralysis, or a simultaneous palsy of the third nerve, with ptosis of the eyelid. Facial nerve palsies, like those involving the brachial plexus, are nearly always unilateral. Bilateral palsy is exceptional.

Since it is not possible to determine accurately the site and extent of injuries resulting in paralysis without postmortem investigation, we are naturally led to the study of lesions resulting in death.

One of the most noteworthy monographs on this phase of birth injury has been contributed by Eardley Holland, of London. This work was taken up under the auspices of the Local Government Board of London. It was begun in March 1914, and the report was presented in March 1922. It is based on the most painstaking autopsy studies of the bodies of 300 newborn babies of a viable age. The examination was undertaken to determine the cause of death in "still-births". In this report it is pointed out that death may occur at 3 periods: (1) antenatal (when the fetus is usually macerated); (2) intranatal (during labor); (3) postnatal (when the fetal heart beats at birth but with respiration never established).

The deaths were classified as accurately as possible, according to the primary causes, as follows: (1) maternal states, such as syphilis

and toxemia; (2) complications of labor, as deformed pelves and placenta praevia; (3) placenta states, as retroplacental hemorrhage; (4) fetal states, such as prematurity and deformities.

Among the actual causes of death, reference was made to 2 conditions which were considered of special interest, namely, syphilis and excessive cranial stress; the first because of its low incidence, and the second because of its unexpected importance.

By most writers, syphilis is regarded as the most common cause of still-birth; but, according to Holland's report, only a relatively small percentage can be thus attributed. His investigations respecting this feature of the studies were most complete, yet among the 300 fetuses examined, there were only 42 cases of proved syphilis and 6 of probable syphilis, or 16% in all; 14 cases were classed as possible syphilis, but in these there was no evidence of the disease in fetus or placenta.

The observation made with respect to excessive cranial stress, defined "as a compound compressive stress, roughly regarded as consisting of 2 elements, (1) a general compression of the whole head, and (2) a simple longitudinal compression by opposite forces, acting at the ends of the long diameter of the pelvis", and their bearing upon the use of forceps and conduct of breech deliveries, are exceedingly valuable and suggestive.

The effect of cranial stress upon the brain and membranes is discussed in detail, and many interesting theories regarding the effect of molding upon the cranium and its contents are presented. Of 167 fresh fetuses examined, the tentorium cerebelli was found torn in 81 (48%); the injury was associated with lacerations of the falx cerebri in 5 cases, and with subdural hemorrhage in all but 6. Of the 81 cases, 46 were delivered by the head and 35 by the breech. Forceps were used in 25 of the vertex presentations, the indications being: contracted pelvis, placenta praevia, and prolonged second stage. In some of the cases, signs of considerable force having been employed were evident. Holland, in this connection, states: "While the forceps may save many lives, it is also responsible for the unnecessary injury and death of many others."

The 35 breech deliveries represent 75% of the total number of breech deliveries examined. The frequency with which the tentorium is torn during breech birth is due, in the opinion of Holland, to the haste customarily advised and employed in extracting the after-coming head. He urges a revision of obstetric teaching with respect to this procedure.

From this report it is apparent that more babies were killed by the complications of labor than died during pregnancy or from maternal or placental diseases.

The observations made by Holland regarding the incidence of fetal injury and fetal death in breech deliveries are in accord with those made by Pierson in the Sloan Hospital, New York. This author reports 142 viable primary breech deliveries, with natal or neonatal death in 18 or 12%. He also reports 87 viable version and breech extractions, with intranatal or neonatal death in 18 or 26%. As regards the cause of death, Pierson found spinal cord hemorrhage in 17 or 47% of the total of 36 cases. Fractures of the vertebrae were found in 14 or 38%. Intracranial hemorrhage was present in 44%, though this was marked in only 25%.

In an analysis of the spinal fluid of 423 newly born negro babies, Roberts found that 60 (more than 14%) contained blood. In the 60 babies in whom spinal hemorrhage was found, the trouble was attributed to trauma in 58 and to hemorrhagic disease in 2 cases.

Sharpe and Maclaire, in a series of noteworthy studies made of 400 new-born babies in whom spinal puncture was performed within 12-48 hours after birth, found evidence of excessive cranial stress by the presence of blood in the cerebrospinal fluid in 7-13% of those babies.

Spencer, in a study of 130 still-born children, found intracranial hemorrhage in 53 or 40.7%; 12 of the babies were delivered by forceps, and in all of these hemorrhage was found. Wallich, quoted by Birnbaum, in 143 postmortem studies of still-born babies, found

intracranial hemorrhage in 58; and Litzmann, also quoted by Birnbaum, found spinal meningeal hemorrhage in 33 of 81 autopsies performed on still-born infants.

Sharpe and Maclaire, in a further series of 100 spinal punctures performed on new-born babies, found blood contamination in 6.

Pierson, studying his series of cases with reference to nature of the delivery, encountered difficulty with the head in 57%; with the arms and shoulders in 25%; with the cervix in 11%; and with the placenta and cord in 28%. He pointed out that trauma alone was the probable cause of death in 56% of the 36 babies. Asphyxia, thought to be the most prominent cause of death in breech delivery, was probably accountable in only 5%, while trauma with asphyxia was thought responsible in 39%. Pierson believes that birth injuries and shock following breech delivery cause a greater fetal morbidity and mortality than asphyxia. Accordingly, he advises against unnecessary haste in breech extraction and indicates that hasty action, prompted by fear of asphyxia, is not justified. The diagnosis of death from asphyxia in breech deliveries, he claims, is only justified (1) when there is strong clinical evidence of asphyxia but none of injury, and (2) when complete autopsy studies show characteristic signs of asphyxia but none of injury.

Emphasizing the importance of undue haste in breech extraction, he refers to Potter and others, who claim that 15-20 minutes may safely be allowed to elapse in delivering the after-coming head. Potter has taken as long as 23 minutes in performing an extraction without injury to the child. Indeed, this well known proponent of the operation of version has on more than one occasion with safety delivered the placenta before the child.

From the study of injuries of the infant during delivery, it is observed that many are largely preventable. The means of prevention may be divided into: (1) a wider adoption and higher standard of prenatal care, and (2) more thorough intranatal training with better practice.

In conclusion, it might be of interest to refer to some figures connected with the work in my own department, with regard especially to fetal mortality.

Table I shows a general summarization of neonatal mortality:

TABLE I

	1930	1931	1932	Total
Total deliveries	720	737	962	2401
Total deaths	88	88	62	238
Mortality rate	12.07%	12.53%	6.43%	9.91%
Still-births	23	42	37	102
Still-born mortality rate	3.7 %	5.98%	3.84%	4.2 %
Neonatal deaths	61	46	25	132
Neonatal mortality rate	8.37%	6.55%	2.39%	5.71%
Died during labor	10	15	9	
	1.47%	2.13%	.93%	
Total operative deliveries	110	115	155	
Deaths	23	26	21	
Operative mortality rate (uncorrected)	3.14%	3.5 %	2.18%	

Our records show that 7 deaths resulted from intracranial hemorrhage. There were 18 deaths recorded as due to asphyxia. I am quite convinced that the majority of these resulted from bleeding within the skull.

The above figures refer to still-births. In studying the neonatal deaths, it was found that 16 followed intracranial bleeding, 30 resulted from pulmonary infection, and prematurity accounted for 50. This, in our clinic, we find is the principal cause of death of the newborn.

Table II shows the various causes of still-births:

TABLE II

	1930	1931	1932
Prematurity	1	13	8
Intracranial hemorrhage	2	2	3
Congenital syphilis	9	2	5
Asphyxia	3	7	8
Toxemia in mother	2	1	4
Eclampsia	1	0	1
Macerated fetus	0	11	0
Premature separation of placenta	0	0	1
Placenta praevia	0	0	1
Prolapsed cord	0	0	1
Unknown—no autopsy	5	6	5

Table III portrays the causes of neonatal deaths:

TABLE III

	1930	1931	1932
Prematurity	19	16	15
Bronchopneumonia	22	7	1
Intracranial hemorrhage	10	4	2
Congenital syphilis	11	1	0
Atelectasis	0	3	2
Toxemia in mother	3	0	0
Eclampsia	1	1	0
Placenta praevia	1	0	0
Monstrosities	8	4	5
Impetigo	0	1	0
Enlarged thymus	0	1	0
Asphyxia	0	0	0
Unknown	6	0	1

Table IV depicts the type of delivery in relation to intracranial hemorrhage with the mortality rate:

TABLE IV

		Mortality Rate
Total number of deaths	23	
Died during or following spontaneous delivery	8	.04%
Died during or following breech delivery	5	6.7 %
Died during or following version delivery	3	12.0 %
Died during or following forceps delivery	7	3.2 %

A NEW METHOD FOR RELIEVING PROSTATIC OBSTRUCTION

Vincent P. Butler, M.D.,
Jersey City, N. J.

Of all the gloomy prospects of a wretched existence to the male, after reaching middle life, nothing stands out in such bold relief as the prostate gland causing obstruction. The damaging effects are not so much in the gland itself as on other structures of the body and, through them, on the physical and mental well-being of the individual. The gland may be enormously hypertrophied and yet be symptomless and cause no trouble, as has been demonstrated by accidental findings at autopsy of prostate glands weighing as much as 180 gm., because there was no interference with urinary outflow. Yet a prostatic enlargement so slight as not to be made out by the examining finger in the rectum, may, if it be situated at the site of the median lobe, or where it may cause urethral intrusion, be sufficient to obstruct the free passage of urine, and thereby set up a series of changes which endanger the patient, commencing with retention of urine. As this retention increases, the physiologic processes and anatomic conditions of the urinary tract are changed. The urinary stasis, besides predisposing to infection, results in back pressure on the ureters, renal pelvis and calices, and—if it progresses far enough—on the renal parenchyma. We have thereby set up a series of progressive symptoms so commonly seen in prostatics; frequency, dribbling dysuria, nocturia, hematuria, and urinary retention. We find further, upon cystoscopic and pyelographic investigation, cystitis, bladder trabeculation as a result of long-standing bladder-neck obstruction, impaired renal function with pyonephrosis and pyelonephritis. With the trend toward having the urologist perform the prostatectomies, together with recent advances in blood chemistry, whereby an accurate guide to renal function can be obtained, plus the more careful preoperative care by means of the indwelling catheter or suprapubic cystotomy, the risk in prostatectomy is lessened; but it still remains a major surgical procedure, with all the gravity which accompanies any such operation in debilitated subjects—as so many prostatics are when they come to operation. To the end that the operative risk might be lessened, and equally good results obtained as are obtained in suprapubic and perineal prostatectomy, many methods have been devised for relieving prostatic obstruction by the urethral route, such as the Young punch, Caulk cautery punch, Collings electrotome, Stern and Davis resectoscopes. Each of these instruments has for one or another condition been quite satisfactory, but even in the most adept hands each has its limitations, and none lends itself to universal application. There has recently been devised by Dr. Joseph F. McCarthy, Professor of Urology at New York Postgraduate Hospital and Medical School, using his panendoscope as the basis, an instrument which not only embodies all the advantages of the previously devised instruments, some of which it simplifies, but adds several features. The instrument is made up of the McCarthy panendoscope with a bakelite sheath, and a working element consisting of an electric cutting loop which is attached to the visual system of the panendoscope and controlled by means of a lever which operates the inward and outward movement of the cutting loop. The operator thereby controls the size and shape of the tissue he chooses to cut under vision. Whereas, in the other instrument, the amount of prostatic tissue desired to be removed cannot be so well estimated or where it can be, it is necessary to remove the instrument with each portion that is removed—we now have a method of removing not only the amount de-

sired, but we can actually do so under vision without removing the panendoscope sheath, and thus plasticly revise the prostatic urethra. The danger of secondary hemorrhage is removed because the current is a cutting current, and if, in the procedure, there be any bleeding, these points can be controlled by merely applying superficial coagulation.

Technic. The anesthetic which has been used is caudal, 30 c.c. of 3% solution of novocaine; caudal anesthesia may also be combined with parasacral to give excellent effect, but the anesthetic which has been most satisfactory is a low spinal. If the spinal is used, extreme care should be exercised in passing the instrument. While it is assumed that this admonition may be unnecessary, even in the most skilled hands disaster may result if extreme care is not exercised in passing the large caliber instrument through an already narrowed lumen. A guiding finger in the rectum has proved helpful. Another precaution is the height of the irrigating container; it should not be more than 3 ft. above the patient's hip, for it may thus distend the bladder.

On occasion, if needed, preliminary vasectomy will prevent the annoying complication of epididymitis, while bladder drainage with an in-dwelling catheter for a few days helps clear up the cystitis, and decompresses the bladder. In the occasional patient who cannot well tolerate the in-dwelling catheter, a suprapubic cystotomy under local infiltration may precede the prostatic removal by a few days. This may also serve the useful purpose of removing vesical calculi, which are found in some of these patients. The caliber of the instrument is 28 F., making a rather large one for introduction into the bladder, but by means of the hollowed-out center of the obturator, a small catheter may be first put through it into the bladder and serve as a guide for the ensuing tip of the instrument. The obturator is then removed, and the visual system and working element, which comprise a unit, are introduced into the bakelite sheath and locked securely, after applying the light connection from a battery, and the cutting current is connected. The water is permitted to flow and the procedure started. After ascer-

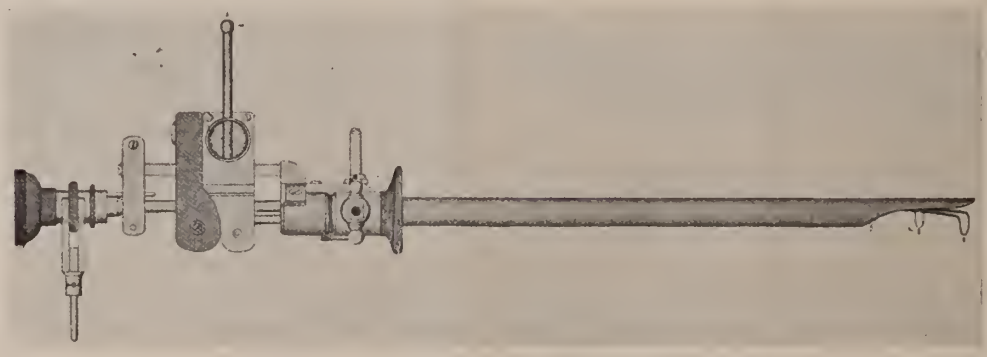


Fig. 1. McCarthy visualized prostate electrode assembled.

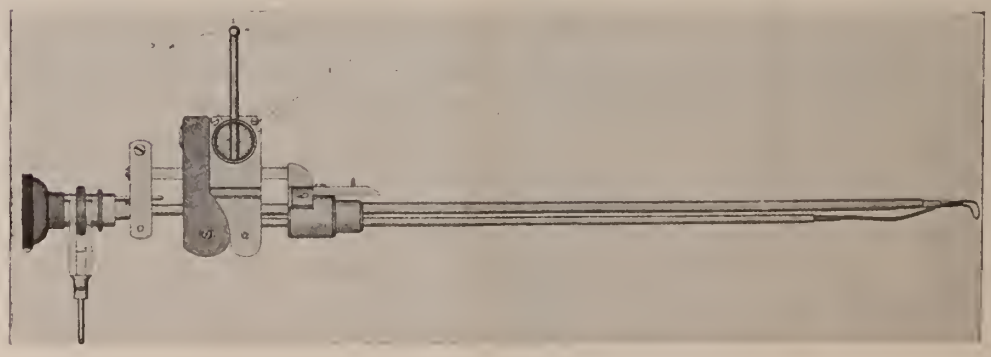


Fig. 2. Shows cutting and optical construction.

taining that the tip of the instrument is in the bladder, it is then withdrawn far enough through the posterior urethra for the verumontanum to come into view, and held at approximately that point. The lever is pressed toward the patient, and the loop is then seen to extend just beyond the portion to be removed, with the loop in the desired position. It is tilted downward and thus approximates the prostatic tissue in its vesical surface by raising the outer end of the resectoscope. The water is permitted to run while the cutting current is turned on, by foot control. The lever is now drawn toward the operator, taking 4-10 seconds, depending on the type of machine supplying the current. The loop can be seen cutting through the prostate tissue, the working element is removed from the sheath, and excised portion of tissue brought with the loop is collected. At times it may adhere to the loop, and at other times it may be washed free by the return flow from the bladder. A useful device here for collecting this tissue is a large-sized tea strainer. This procedure begins at the center, and when a sufficient amount has been removed, the scope is turned to carry out the procedure on the lateral surfaces. The number of pieces of tissue removed will depend upon the amount of obstruction to be relieved, as well as the individual desire of the operator to excise a small or large portion. As few as 3 have removed some obstructions, whereas 20-30 are frequently taken. But the optimum result is obtained not by the number of pieces removed, but by the effective recanalization of the prostatic urethra, so that where before there was obstruction, now we have free passage which we can really see when we have the verumontanum in view and are able to look directly into the bladder. During the procedure, bleeding may be encountered; this is readily controlled because the bleeding points are visible, and by gently touching these points with the loop electrode and applying the coagulating current, hemostasis is complete.

When satisfactory control of bleeding has been accomplished, the working element is removed, and through the sheath a 24 F. soft rubber catheter is inserted into the bladder, and the sheath removed over it. The catheter is strapped in place, and the operation, which has consumed about 20 minutes, is completed. The patient, in marked contrast to the condition presented by the open forms of operation, is returned in excellent condition to bed. Frequent irrigation, as often as every 4 hours for the first day, and then 3 times a day, using boric acid solution, is instituted. The catheter is allowed to remain in place 2-4 days, and if, at that time, no blood is present in the urine, the bladder is filled, catheter removed, and patient permitted to void voluntarily. Subsequent treatment of these cases consists of bladder irrigation, and administration of copious amounts of fluid. The immediate results in a few of these patients have not been conspicuous. Some patients may have an increased frequency of urination immediately following operation, but this is transient, and the ultimate results are indeed gratifying, and in by far the greatest percentage of them, have been entirely satisfactory. It has been shown that no scarring occurs, because this operation is a plastic one which attempts to re-mould the canal to its natural contour. Many of the unfavorable results are no doubt due to improper selection of patients for this type of operation. Most satisfactory results have been obtained in: (1) carcinoma of the prostate where there is obstruction, with residual urine, and the operation removes this obstruction; these patients, while their carcinoma is never cured, are saved many months of suffering and given a comfortable prolongation of life; (2) median bar, that is, in cases where there is fibrosis of the vesical neck; (3) hypertrophy, where the hypertrophy involves the middle lobe or the middle and lateral lobes, and where there is an intrusion with obstructive symptoms.

While, in the course of the past 9 months, not a single enucleation of the prostate has been performed by the writer, it must not thereby be inferred that this method has entirely supplanted such operations. It is clearly recognized that there is a group of cases, constituting probably 5%-10% of prostatics, which does not well lend itself to endoscopic revision. In the enormously hypertrophied adenomatous prostate, where the tortuosity of the urethra is so marked, and the obstructions

it causes are so irregular and multiple, that a satisfactory manipulation is extremely difficult, enucleation of the gland is preferable. However, since the scope of cases included in this procedure has, with added experience and technical refinements, been gradually broadening, it may well be that this method may be used satisfactorily in all cases of prostatic enlargement.

As to permanency of the results, we can only determine this after a period of years. It is the consensus of opinion of those with the widest experience in this procedure that, regardless of pathology, symptoms will be relieved; in the carcinomatous type, symptoms are temporarily relieved; while in benign cases, the relief is permanent.

METHODS FOR IMPROVING RESULTS IN CANCER OF THE LARGE INTESTINE AND RECTUM

Vincent Farmer, M.D.,
Hackensack, N. J.

For progress it is essential that the physician maintain the possibility of malignancy of the large intestine and rectum. Cancer of the lower part of the gastro-intestinal tract is relatively infrequent, as compared to that of the stomach, and conclusive evidence is late to appear. The symptoms in the beginning may be so obscure that they are either not considered important or not properly interpreted, or else, are wholly disregarded.

From a clinical standpoint, 2 symptoms are significant: (1) disturbance in intestinal function; (2) blood in the stool. The intestinal stasis is often recognized by increasing constipation; more frequent physics being required to overcome it. When a patient over 40 years of age, who previously had regular habits, complains of increasingly difficult intestinal function, he should be looked upon as a malignancy until repeated examinations have eliminated this contingency. This change in the lumen will be noticed sooner in cancer of the left half of the colon than in the cecum or ascending colon, where the contents are more liquid and consequently can pass through even a marked constriction easily. It therefore behooves the physician never to prescribe medicine for intestinal stasis in elderly persons until certain, by all possible examinations, that the diagnosis of cancer needs no further consideration. Where cancer has been present for some time, the attacks of constipation may be followed by diarrhea. This diarrhea is often caused by a colitis occurring above the stenosis, due mostly to congestion from feces and laxatives. Other disturbances of intestinal function, such as epigastric distress, dyspepsia, or impaired appetite, may be the only manifestations of the growth, and may be confused with peptic ulcer, cholecystitis or chronic appendicitis.

Profound secondary anemia and weakness are frequently associated with carcinoma of the right half of the colon. Malignancy of the cecum should always be excluded by roentgenologic examination in cases of unexplained secondary anemia.

Blood in the stool is noticed sooner when the cancer is closer to the anus, while cancer of the cecum rarely shows macroscopic blood, and often requires repeated stool examinations before microscopic blood can be demonstrated. In every patient with visible bleeding from the rectum, proctoscopic examination should be made and supplemented by x-ray examination.

A palpable mass, felt through the abdominal wall, can be felt only in the advanced stages, and even then is felt mostly when the abdominal wall is thin. The findings on palpation are usually inadequate, the intestinal contents sometimes are felt as a hard mass above the stenosis. On palpation with examining finger in the rectum, it is important to place the patient in different positions; not infrequently, in the lithotomy position, a tumor of the sigmoid may be pushed down so as to be felt in the rectum. Visible peristalsis appears only in the late stages, where there is hypertrophy of the intestine above the constriction. We frequently see patients who have not had any loss in weight, and not infrequently they show a gain in weight, even with cancer. In the latter group, there may be more absorption of nourishment, and also

accumulation of food in the large bowel. Gain in weight by no means indicates absence of cancer.

Proctosigmoidoscopy should be a routine procedure before every operation for hemorrhoids, followed by x-ray examination if necessary. This latter should not be limited to a barium enema, but a careful gastro-intestinal series should be done when there are no signs of obstruction, so as to eliminate the possibility of primary cancer of the stomach, with metastasis in the pelvis. Carcinoma of the cecum may be easily overlooked in an x-ray clysma, as the stenosis may be taken for the normal end of the cecum.

In the barium enema examination, there are many fallacies. A very fluid enema can run through a stricture which might seem impossible from an examination of the specimen. Another fallacy occurs from overlapping, a distention above or below the stricture itself. A negative barium enema finding should never be accepted without question; it is thus that many cancers have become inoperable. Cancer is often not found by the x-ray picture until it has already caused complete stenosis. In all cases the barium should be given under the fluoroscope, and examination made not only in the anterior but in the oblique and lateral positions. In some cases it is advisable to inject air after part of the barium has been expelled, to show small growths in the x-ray film. An exploratory celiotomy, performed under local anesthesia, is not dangerous, and enables one to operate upon an early-stage cancer. When signs of chronic obstruction are already present, only an x-ray clysma should be made.

Aside from a timely diagnosis, the physician should stress the importance of early operation, despite the predisposition of people to doubt operative value in cancer cases, by combating it with a presentation of the real curative results obtained. In rectal cancer, even in elderly poor-risk subjects, where, on this account, the sacral method is advised, the result of the operation is good in spite of the advanced age. The mortality varies between 5% and 15%, depending upon how the patients are chosen. This mortality is considerably reduced if the intestine is well cleaned out by colostomy made previously. However, only a small percentage of cases of rectal cancer should have a posterior resection. The combined method abdominoperineal gives best results, inasmuch as the glands in the mesosigmoid, up to the bifurcation of the aorta and above, can be removed with tumor. The resection is more extensive. Many patients with rectal cancer, on account of the higher situation, short mesocolon fixation, far up on the lateral pelvic wall, or glands that have infiltrated high up, or for other reasons, cannot be operated upon by the sacral method alone.

In some cases of cancer of the large bowel, where it has been possible to evacuate the bowel by frequent enemas for a period of time previous to the operation, resection can be done at one operation but seldom without great danger. If the evacuation is no longer adequate, which is particularly common in cancer of the left colon, because of the already firm consistence and stasis of the intestinal content, cancer of the large intestine can be prolapsed, the bowel clamped proximal and distal to the tumor, which is removed by cautery, closing the artificial anus at a later operation; otherwise, a cecostomy, which allows for satisfactory evacuation of the colon, then extensive resection with a side-to-side anastomosis, later a third operation, closing the cecostomy. There are many methods of procedure, but whichever is preferred, one of the 2- or 3-stage operations is safest and most practical.

Where intestinal exclusion is complete, one must make an evacuation fistula. The 1-stage primary resection should not be done even in cases of the right colon, where the gut is distended, as occurs in acute or chronic obstruction, for the reason that the sutures do not hold and peritonitis is imminent. Contrary to general belief, advanced age does not make the prognosis considerably worse in radical operations of cancer of the large intestine. The results in elderly patients can be improved when the surgeon eliminates deep general anesthesia (paravertebral, parasacral anesthesia, etc.), using combined anesthesia when necessary.

Patients frequently lay great stress on the matter of continence following operation. After the 3-stage resection in cancer of the

large intestine, one can be certain of regaining normal stool movements. In rectal cancer, continence is possible when the cancer is low in the rectum, and the sphincter is preserved in the posterior resection. When the cancer is near the anal canal, there is possibility of a local relapse if the sphincter is not sacrificed. When the cancer is located higher up, the sphincter can in some cases be preserved, and the continuity of the intestines be procured by circular sutures, after resection of the tumor; or, if the mesentery of the sigmoid is long enough and well nourished, it may be pulled down. Frequently, however, in these operations, sutures do not hold, sacrofistulas develop, and the operation is not a true radical resection of the area involved. By proper diet, and irrigation by the patient after bowel movement, the intestinal passage can easily be controlled so that it does not interfere with daily routine or social activities.

From the viewpoint of the patient and relatives, the question of permanent cure is of inestimable value. The reports of various clinics and surgeons show an amazing percentage of cases up to 20 years. In rectal cancer, more easily diagnosed because of its position, one should expect a higher percentage of cures than in cancer of the large intestine, which is often obscured until in late stage. Generally speaking, in cancer of the large intestine, cures are considerably higher than in cancer of the rectum. Turner reports that of 115 patients discharged as cured, 52 remained free from relapse for 5 years. Finsterer reports that 40.8% of all resected patients, and 53.6% of patients discharged as cured remained free from recurrence for 5-19 years. Rankin determined the rate of recurrence in 602 cases at the Mayo clinic of carcinomas for which various procedures were employed. Of these, 93% were traced, 47.85% were alive after a period of 3 or more years; 33.77% were alive 5 years or more; and 23.13% were alive 10 years or more. In 1929, at the Mayo clinic, operations were performed on 381 malignant lesions of the large intestine—221 were resected, an operability of 58%. The mortality was 12.3%.

In the study of comparable results, one should take cognizance of the fact that some surgeons have improved their technic to the extent that a large percentage of their patients are considered operable; and it seems that those whose procedure is radical have a larger number of permanent results. This does not necessarily mean that the mortality is higher, but it indicates a better preparation of patient, careful technic, and advanced methods of anesthesia.

While the results obtained for malignancy of the large intestine and rectum leave much to be desired, improvement depends in great measure upon the coöperation of the physician. In every case of disturbance of intestinal function, unexplained secondary anemia, dyspepsia, or blood in the stool, the possibility of malignancy must be considered. A thorough investigation of the gastro-intestinal tract should be made, when any change of function persists for a period of weeks. Thus, patients would be referred to the surgeon before disastrous symptoms such as cachexia, loss of weight, dehydration, and metastasis are in evidence. Diagnosis requires a proctoscopic examination, barium clysma, and, if necessary, a laparotomy, before cancer is eliminated. Education of the patient creates a close coöperation between patient, physician and surgeon, so that further advancement can be accomplished.

PNEUMOTHORAX THE TREATMENT OF CHOICE IN PULMONARY TUBERCULOSIS

M. James Fine, M.D.,
Director, Tuberculosis Division, Department of Health,
Newark, N. J.

The accepted treatment of pulmonary tuberculosis today is based upon the principle of *rest*. Whether this be achieved by sanatorium care, phrenicotomy, pneumothorax or thorocoplasty, they have the same principle in common. Only since recognition of the principle of rest in the therapeutics of pulmonary tuberculosis has mortality from the disease declined. Yet, in spite of convincing statistics, an appreciable percentage of the profession

either have not familiarized themselves with the various methods of technic or hesitate to utilize any other mode except sanatorium and climatic treatment.

All of the above-mentioned methods have proved useful in their place. Indications for each are well recognized and clearly defined. In this paper, I propose merely to emphasize some points I have been advocating since 1920.

The treatment of choice in pulmonary tuberculosis entails a consideration of the individual—his mentality, temperament, economic status and vocation—and of society, which must be protected by all public health methods at our disposal. One should elect the form of treatment after due consideration has been given to these matters.

Given a case of early unilateral tuberculosis in an intelligent individual who can afford sanatorium care and would profit considerably from the instruction at a reputable institution, the sanatorium may be of great value. On the other hand, one may become a neurasthenic and quite depressed by absence from home and the exacting routine. Many have been reported where actual harm has resulted. Moreover, the treatment is not always efficacious in itself and has to be combined with one of the other forms. The treatment in any case is long and tedious.

For years I have contended that the best results in pulmonary tuberculosis obtained with artificial pneumothorax have been with those in the early stage and with unilateral involvement. It has been difficult to convince some men that, in many instances, this treatment is superior to the simple rest cure. The general objection has been that if a patient can get well without administration of air, he is entitled to the simplest form of treatment. I endorse the objection as well, if we can be certain we are dealing with the right kind of patient under favorable circumstances. I believe, however, that after a reasonable time, in such cases, where improvement has not been noticeable or there is evidence of extension of the tuberculous process, the individual should be given artificial pneumothorax therapy.

In those patients where the lesion is discovered early and the patient is not the type for sanatorium care, artificial pneumothorax is the treatment of choice. The patient is at home, the collapse insures rest of the affected part, and refills are given when necessary. The time element is considerably diminished, and the patient is restored to health and may seek gainful occupation in much shorter time. The results of early collapse are so favorable that I prefer it to all other methods in my own practice. I have the advantage of treating these patients before adhesions set in, and the collapse is given under ideal circumstances. It is only when the patient or physician insists on a sanatorium trial, that I now consider sending such patients away.

Through experienced hands, the treatment is simple. The dangers attendant are negligible for all practical purposes. The initial administration is always given with an assistant, who watches the pulse and respirations and is ready to administer emergency treatment. Pleural shock, complete collapse, embolism, and rupture of a vessel are rarities. Fluoroscopic examinations should be made before and after each refill. Usually, the general practitioner does not care to acquaint himself with the details of the technic, and the work is done by a man in the field of tuberculosis exclusively.

Artificial pneumothorax is not confined in its usefulness to cases of early unilateral tuberculosis. In patients with extensive lesions confined to one side, with cavitation, where the adhesions do not prevent entrance into the pleural cavities, spectacular results are often attained. The cavity or cavities are collapsed and successive x-rays show their gradual obliteration. Even where there are numerous adhesions, frequent small amounts will help break these adhesions, and after several times, the quantity of air introduced will be optimum.

Artificial pneumothorax in selected cases may be given to patients with bilateral involvement. The results are not infrequently favorable. The side with most extensive involvement is treated first, and then the opposite side collapsed. I have had several patients who were so treated and are at work.

Case 1. M. C., aged 19, waiter. Involvement of both lungs, most extensive on right side. No sanatorium care. Saw him while having hemorrhage. Lived in a congested neighborhood and remained there during treatment.

First pneumothorax on April 19, 1931. Refills every 2 weeks. Treatments discontinued Dec. 31, 1931. Gained 35 lb., working. Plates (1) and (2).

It must be remembered that pneumothorax can be no better illustrated than by examination of the sputum. Given a patient with unilateral involvement and a positive sputum, the latter will invariably become negative after the second or third successful refill. If we assume



This illustrates case No. 3 before treatment is started.

is a surgical procedure. However, it is to be considered the simplest of all modes of collapse therapy.

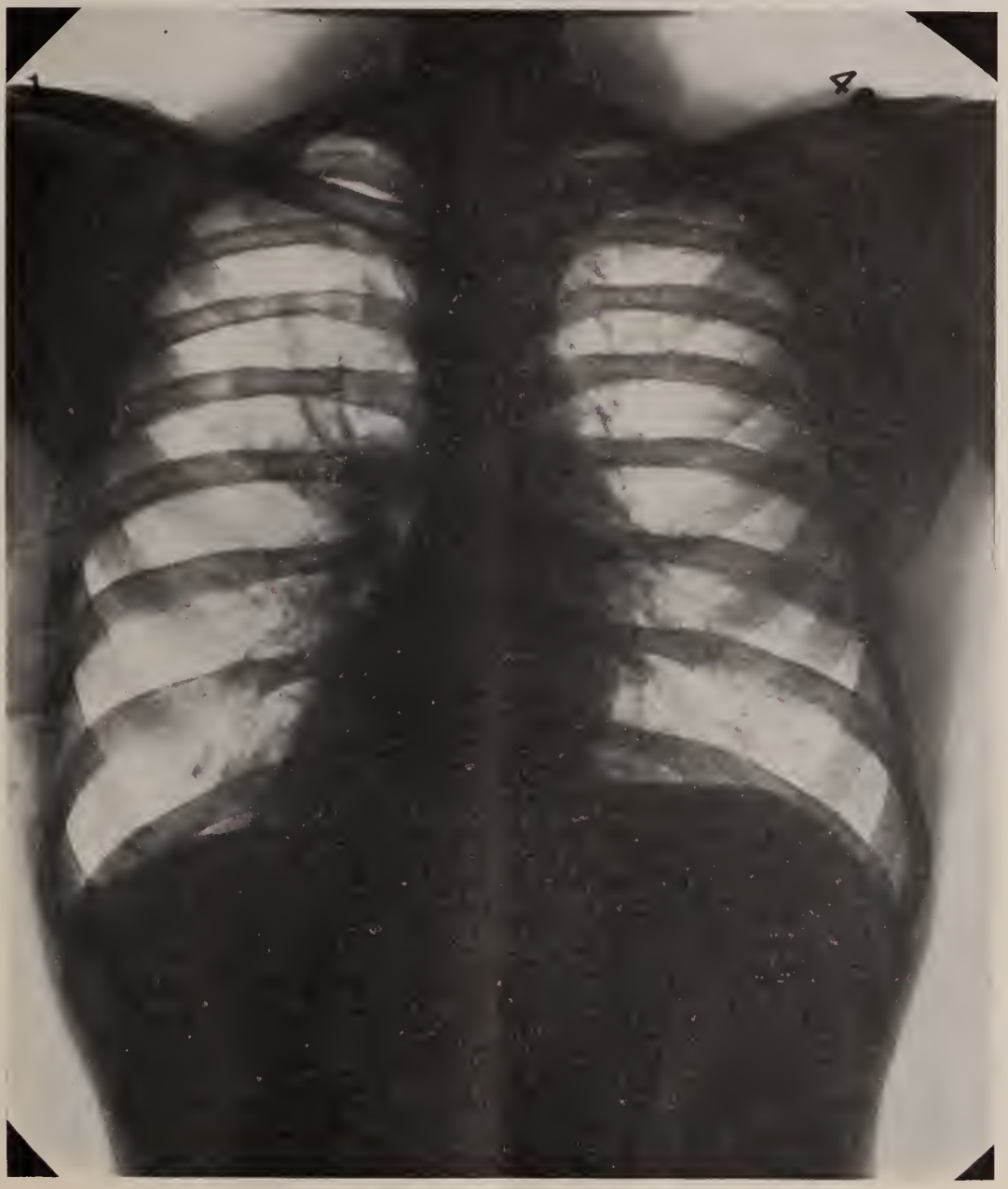
The importance and certainty of its results that such collapse therapy does nothing more than effect such a result, the advantages to the patient's immediate family and to society in general justify universality of the treatment.

At present, no more efficacious method can claim priority in treatment of early tuberculosis than does artificial pneumothorax.

With disappearance of the tubercle bacilli in the sputum, the activity ceases, temperature

many instances after the first and second injection of air. No other method can achieve so rapid improvement in so short a time.

Case 2. J. E. S., aged 43, banker. Involvement of upper left and right lower lobe.



This illustrates case No. 3 after fifth refill; patient still under treatment.

becomes normal, patient gains in weight, tiredness and fatigue disappear, and above all, the patient may return to work. These results, it should be emphasized, are accomplished in

Weight 127 lb., family history negative. Was in bed 6 months before seen by author. Positive sputum. Pneumothorax given on left side. Patient back to work with negative sputum in

2 weeks. Gained 8 lb. No temperature, no cough, no expectoration. Small adhesion at apex. Still given refills every 2 weeks.

Case 3. H. L. S., aged 23, insurance official. Married, one child. Family history negative. Previous history negative. Complained of cough 3 months. Seen in consultation and advised pneumothorax. Sputum positive. Involvement over left side with cavity at apex. Pneumothorax given. Refill given 3 days later, and patient returned to work. Refills every 2 weeks. Sputum negative. Temperature normal. Gained 10 lb. Received treatment for last 4 months. Has a partial collapse and is still under treatment.



This illustrates case No. 5, showing the plate before collapse of the cavity.

The length of time for administration of air depends largely upon conditions. The duration must be studied separately in each pa-

tient. Usually, therapy can be discontinued after 5 or 6 months with permanent results. The patient should be closely watched, however, for another year and should report periodically to his attending physician for further advice.



This illustrates case No. 5, showing the plate after collapse of the cavity.

Case 4. W. R. C., aged 36, married. No children. Restaurant manager. Family history negative. Hemorrhage 8 months prior to examination. Bedridden for 7 months, condition unchanged. Involvement of entire right side, with cavitation at apex. Positive sputum. Gave 250 c.c. of air at first injection. Refills every week. No response to treatment for one month. Breathing at apex was not diminished, patient was in bed, was not fluoroscoped. After fifth refill, x-rays taken. Adhesion found at fourth rib. Cavity at apex not col-

lapsed. Pneumothorax continued but adhesion remained. At each refill, for 11 months, 700 c.c. given. Treatment discontinued. Patient now working and feels well. Sputum negative, temperature and pulse normal, no cough. Remained 2½ years. Pneumothorax advised at that time and refused. Weight at time of examination by author, 165 lb. Dysphagia. Hoarseness, laryngeal tuberculosis. Entire right side involved. Pneumothorax adminis-



This illustrates case No. 6, showing plate after second refill

Case 5. E. M., aged 27, automobile mechanic. Family history negative. Three years before I saw him, he developed pain, cough, expectoration of blood. Sent to sanatorium. tered. Condition steadily improved. Gained 12 lb., and is well and working. Pneumothorax discontinued after 5 months.

Case 6. A. L., aged 23, housewife. One

child. Tuberculosis discovered following childbirth 6 years before seen by author. Lesion on right side. Pneumothorax given at that time and continued for 6 months. When patient was first seen by author, she was well and there was no activity present. Two months later she fell and injured chest. Began to expectorate blood and showed signs of activity. Successful artificial pneumothorax given. Small adhesion at apex on right side. In attempt to break up adhesion, positive pressure was used. Patient developed massive effusion. Treated expectantly. Fluid absorbed. Patient well and working. Gained 55 lb.



This illustrates case No. 6, showing plate after complete collapse when treatment had been discontinued.

Should there be evidence of activity with the re-expansion of the lung, there should be

no hesitancy in renewing the collapse. When one course has been ineffective, a second course is often all that is necessary.

The "Pneumothorax Clinic" at the Newark City Health Department, under the author's



This illustrates case No. 8. Picture before pneumothorax given.

direction has impressed us of late with an important factor in civic economy. Because of the long waiting lists at the sanatoriums, we have, in numerous instances, instituted collapse therapy and have often withdrawn applications due to the patient's improvement. The patient, furthermore, has frequently returned to gainful occupation, with the hazards of his presence to his family and society eliminated. This has led us to the conclusion that if such work were carried on in a community over an extensive scale, the savings to the city would be tremendous. Case 1 illustrates that point.

In spite of all these findings, a patient will

occasionally refuse pneumothorax treatment against the advice of his family physician and the specialist. The application of 5-10 lb. of buckshot to the side with greatest involvement will so impress a patient with its efficacy, that



This illustrates case No. 8. Picture after pneumothorax given.

he will agree to the more certain method of collapse therapy.

Case 7. F. P., aged 18, single, female. Dressmaker. Family and previous history negative. Weight 105 lb. Menses irregular for 4 months prior to examination. Seen during hemorrhage. Involvement of left upper lobe. Pneumothorax advised. Refused. Five pounds of buckshot applied to left side. Hemorrhage stopped. Condition improved. One month later, streaked blood again, and was admitted to sanatorium. Remained 8 months. Condition on discharge worse. Pneumothorax given and continued 4 months. Patient now working, feels well. Still under supervision.

Where adhesions are extensive and collapse impossible, or where one wishes to determine the side of greatest activity, the application of weights is a useful adjunct.

Case 8. E. M. S., aged 23, married, housewife. One child. Family history negative. Seasonal attacks of hay-fever. After a course of pollen desensitization, developed violent coughs. Examination of sputum proved positive. Physical examination revealed 2 cavities on right side and cavity at left upper lobe. Activity over both sides. Was difficult to determine most active side. Five pounds of buckshot placed on left side for 2 weeks. No response, changed to right side. Temperature became lower, expectoration less. Collapsed right side. Continued for 2 years. Cavities collapsed. Condition improved, temperature normal, gained 5 lb. Expectorates very little but marked dyspnea. Lung allowed to re-expand. Performs light duties at home.

Artificial pneumothorax may be considered an emergency measure in the treatment of uncontrolled pulmonary hemorrhage. It is used where all other measures have failed. I have discussed this subject fully in a previous paper.

Comment and Summary

Experience has convinced me of the superiority of artificial pneumothorax over any other method of therapy in treatment of pulmonary tuberculosis. It is applicable to cases of unilateral and bilateral involvement. Best results are obtained in early cases with unilateral involvement. It is a simple surgical procedure in skillful hands. The duration of treatment depends upon the individual. The average period extends from 6 to 8 months. The rapidity of action is evidenced by the early absence of positive sputum, lowering of temperature and early return of patient to gainful occupation. It is one of the surest methods to remove the menace of tuberculosis from society. From all points of view, it is the most economical mode of treatment of pulmonary tuberculosis. Carried out on a civic basis, it would obviate the problem of sanatorium congestion.

I do not ordinarily advise sanatorium care to my private patients any longer. If they prefer it, I urge them to have it supplemented with artificial pneumothorax. The response of the patient and family is always gratifying. The earlier the profession at large becomes cognizant of the beneficial results of artificial pneumothorax, the lower will go the mortality statistics of pulmonary tuberculosis.

In a subsequent paper, I propose to show the applicability of artificial pneumothorax to other pulmonary conditions. The rationale of the treatment appeals to one's sense of therapeutics because it lessens the trauma to parenchyma of the lung and limits the motion of the chest, giving the affected part a chance to heal.

METASTATIC LATERAL SINUS THROMBOSIS

Henry Z. Goldstein, M.D.,
Newark, N. J.

Although lateral sinus thrombosis secondary to mastoiditis and other ear diseases is fairly common, its association with infective processes outside the head is exceedingly rare. To the scanty literature existing on the latter complication, I should like to add another case.

Mr. L. S., white, 42 years of age, married. Admitted to Newark Beth Israel Hospital on February 7, 1932.

Complaints: Headache, chills, fever, painful swelling on left side of head.

Past medical history: Well save for an attack of pleurisy 5 years before present illness. About 3 years ago, struck head against curbstone but sustained no fracture and felt no ill effects.

Present illness: Patient has not felt entirely well since pleurisy 5 years ago, but has not been incapacitated. On Christmas evening, he went to a party, where he had more than his share of whisky of doubtful vintage. Next morning he was seized with abdominal cramps but did not vomit. The pain was general in type, lasted about a week, and was followed by slight jaundice. Patient attributed illness to poor liquor. Attack lasted several weeks, and then gradually cleared up, leaving him

weak and exhausted. He then began to suffer from severe occipital headaches. Headache continued as the sole symptom until a week before admission to hospital. He then noticed that there was a painful swelling in the head, above and behind the left ear. Headache became worse, swelling larger and more painful, and patient began to feel nauseated and vomited. Nothing was found clinically in the abdomen at this time, and the symptoms were referred to the head.

I saw the patient on February 7, and admitted him to the hospital.

Physical examination: The patient, acutely ill, was shaking violently, and complaining of a chilly sensation. Temperature was 103°. He insisted that he felt fine, but seemed very toxic. No meningeal signs. No Kernig. No Brudzinski. No stiff neck. About an inch above and behind left external auditory canal, there was a tender, fluctuating, boggy area about the size of a silver dollar. Edema extended up to the vertex. The bone could not be palpated under the fluctuating area. Had a fine nystagmus on looking in both lateral directions. No ocular palsies. No cranial nerve involvement. Pupils reacted normally. Fundi normal. Septum deviated to left with purulent discharge on floor of nose, extending toward middle meatus. Right ear normal; left drum, dull and canal narrow. No perforations. No pus in ear. Tonsil tissue present on both sides, but not particularly inflamed. Lungs seemed normal. Abdomen: soft; no tenderness; no masses felt.

Dr. Henry C. Barkhorn saw this patient with me, and a tentative diagnosis of left mastoiditis, osteomyelitis of the skull, and sinus thrombosis was made.

X-ray pictures of the mastoids and skull revealed no fracture, but an old sclerosis of the left middle ear and antrum was present.

Blood count at this time revealed: hemoglobin—46%; red blood cells—3,100,000; W. B. C.—26,000; polymorphonuclear leukocytes—88%; lymphocytes—10%.

The patient was operated on during the day of admission. A large abscess was found stripping up the periosteum, 1 in. above and behind left ear. About 1 oz. pus, with a marked coli odor, was evacuated. There was erosion of the bone overlying the lateral sinus. Eagleton's unlocking the petrous pyramid was done. Bone over lateral sinus was removed back ot torcula. Sinus was covered with a pseudodiphtheritic membrane, and was thrombosed and necrotic from 1 in. behind ear all the way to torcula. Sinus was opened, bleeding controlled with tail sponges, and wound left open.

Diagnosis: Left lateral sinus thrombosis.

The patient was transfused twice on day following. On February 10, blood culture and culture of abscess were found negative for growth. On February 12, patient was again transfused. February 13, complained for first time of pain in left side of the chest. Diagnosis of metastatic pneumonia was made. X-rays revealed bronchopneumonic type of congestive infiltration of both lungs. February 17, condition gradually became worse; marked dyspnea and cyanosis; pulmonary edema intervened; death at 10.30 p. m.

The laboratory reports were interesting in comparing the young leukocyte forms (stabs) with the percentage of degenerative toxic granules in the granulocytes.

Date	W. B. C.	Polys	Lymphos	Toxic Granules	Stabs	HBG
Feb. 7	26000	88%	10%	....	....	46%
Feb. 9	26600	52%	3%	40%	42%	....
Feb. 10	26250	58%	3%	48%	35%	....
Feb. 11	.....	73%	8%	78%	17%	....
Feb. 12	20000	62%	8%	56%	26%	....
Feb. 14	35000	82%	4%	99%	11%	56%
Feb. 16	35600	86%	5%	93%	7%	....

The stab count fluctuated between 11% and 42%, while on the other hand, the toxic granules in the granulocytes gradually increased to 99%, and gave an increasingly poorer prognosis.

Autopsy findings: I shall give a brief summary of the pertinent findings. The gastrointestinal tract and head findings were the most significant. There were adhesions between the urinary bladder and cecum at the point of origin of appendix. Dissection of this portion showed an appendiceal abscess which had become adherent to the bladder. There was a large fecolith in the abscess area. Gallbladder was normal. Liver normal in size and showed a scar in the right dome, which was

retracted and appeared to be the site of a healed infarction. In the caudate lobe, on section, could be seen an abscess involving almost the entire lobe. Section through this abscess showed it to be continuing toward the portal vein. Externally, a small pocket of pus was present at the dome of the diaphragm, near the emergence of the esophagus.

No evidence of meningitis. Section of brain showed no evidence of pathology other than congestion of superficial vessels. There was a slit in the lateral sinus on left side of brain, extending from temporal region posteriorly to 1 in. from torcula. At the point where the slit stopped, there was a suppurating thrombus which extended to the torcula. Recent blood clot was found in transverse longitudinal sinuses. Cavernous sinuses were negative. There was no evidence of otitic infection.

Cause of death: Left lateral sinus thrombosis. Secondary causes: Peri-appendiceal abscess; portal sepsis with liver abscess; acute fibrinous pleurisy on left side; pulmonary edema; and organizing pneumonia on left side.

Summary

When the patient first became ill with abdominal cramps, he probably had an appendicitis which ruptured, giving rise to an appendiceal abscess which healed over and became bound by adhesions. Extension to the liver took place, accounting for the jaundice, and giving rise to a liver abscess and portal sepsis. A bacteriemia was present at some time, and organisms lodging in the lateral sinus directly gave rise to an infective thrombus. Subsequent involvement of the emissary vein may have caused the local abscess of the scalp, or, primary lodgement of the organisms may have been in the bone or scalp, and later have caused the thrombosis. The pneumonia was also due to the showers of bacteria involving the lungs.

It represents one of the rarer forms of metastatic involvement of the lateral sinus subsequent to an abdominal infection which, strange to say, gave very little symptomatology.

ACETARSONE (STOVARSAL) IN THE TREATMENT OF CONGENITAL SYPHILIS

N. B. Heller, M.D.,
Newark, N. J.

Ehrlich, in 1909, while engaged in his extensive work on arsenic compounds, developed one known as No. 594, but it was considered by him as too toxic for therapeutic purposes. The laboratory animals invariably developed extensive inflammatory lesions at the site of injection. Also, the spectacular results obtained by employment of the newer compound, No. 606, salvarsan, far overshadowed whatever favorable results were obtained by employment of compound No. 594. This preparation, known in Germany under the name of spirocid, and in France under the name of stovarsal, is manufactured in the United States, and accepted by the Council on Pharmacy and Chemistry of the American Medical Association as acetarsone. It is sold in the form of compressed tablets, 0.25 gm. each; can be easily crushed to a white odorless powder, slightly soluble in alkaline solution, and in alkaline carbonates. According to the manufacturing chemist, it has the structural formula: HO—NHCOCH3—ASO (OH), and acetyl-4oxy-3aminophenyl arsenic acid. As seen from this formula, it is a pentavalent arsenic compound closely related in structure to salvarsan, with the difference that the arsenic in salvarsan is a trivalent. Acetarsone contains more than 27% arsenic; in its arsenic content it ranks between salvarsan and neosalvarsan.

While Ehrlich considered it as of little, if any, therapeutic value, other workers were interested to study its properties and fate when introduced in the animal organisms. Chen, Anderson and Leake found that oral administration is relatively harmless, and that large amounts of arsenic appear in the urine after such administration. This encouraged further research, with the result that the drug was found to be valuable in preventing experimental syphilis in laboratory animals. If given in large doses, we get the same clinical symp-

toms as from any other arsenic poisoning, i. e. coryza, bronchitis, sore throat, chills, urticaria, pruritus, jaundice, eczema, edema, albuminuria, etc.

Acetarsone is successfully employed in amebic dysentery. It has also been tried with different results in ulcerative colitis, pemphigus, yaws, and other Spirillum infections such as intestinal spirochetosis, trypanosomiasis, spirillary bronchitis, Vincent's infections, etc.

In 1928, while visiting the Oppenheim clinic, I found all attendants were instructed to use acetarsone as a routine prophylactic. Whenever any of them sustained an accidental injury with a needle or otherwise, they were given the drug orally. The usual dose was 2 tablets of 0.25 gm. each the first morning, taken in water on an empty stomach, ½ hr. before meal; and 3 tablets were given on the second and third mornings before meal. This was considered to be the best prophylactic. After a year and a half of observation, none of the suspected, exposed patients who had a negative Wassermann reaction became positive. In some cases of syphilis that do not respond to orthodox antisyphilitic therapy, a course or 2 of acetarsone will often change the entire clinical picture. In tabes dorsalis, it is also advocated. The same applies to dementia paralytica, especially in its early stage.

The consensus of opinion is that acetarsone is not as efficacious in the treatment of adult syphilis as are the arsphenamine preparations but it is more efficient than bismuth or mercury. With Oppenheim, Levaditi, Fournier, Guenot and Schwartz, and others, we consider acetarsone as a valuable adjunct in our therapeutic armamentarium in combating this infection. The administration by mouth, in conjunction with weekly injections of bismuth, is advised whenever there is intolerance, or inability to use the other arsenicals intravenously. We give 2-4 tablets in water on an empty stomach, ½ hr. before breakfast, for 5-7 days, bismuth being administered simultaneously intramuscularly, and consider the following conditions as indications for the use of acetarsone in adult syphilis: (1) hypersensitiveness to salvarsan preparations; (2) inability to find a vein, or obliteration of the veins; (3) inability to treat the patient other than by mouth; (4) involvement of vital organs, as liver, kidney, aortitis; (5) inability on the part of the patient to attend regularly. Patient is carefully instructed to watch for the earliest signs of toxic symptoms. Should any develop, treatment is stopped immediately, and patient reports to the doctor for examination and advice.

When we first see a case of congenital syphilis, the outlook is gloomy. This view is justified from observing patients who did not receive the benefit of proper medical supervision and treatment. Time and again we see gratifying results in patients who received proper and adequate treatment. This applies to the clinical picture as well as laboratory findings.

With the widespread employment of the Wassermann and Kahn tests in search of latent syphilis, especially in prenatal conditions, a large number of cases are detected that otherwise could not have been so classified. The patients all receive some form of antisyphilitic treatment. This is especially true in our centers of population, where there is easy access to clinics or medical center. This has reduced the incidence of syphilitic manifestations in the newborn. In the cities, active congenital cases with clinical symptoms are rare. Many apparently healthy infants born in syphilitic families have a persistently positive serum reaction. Admitting that not all would later develop syphilitic lesions, experience has shown that quite a percentage of these infants later, as they grow up, show some stigmas of congenital syphilis.

Whether there are any clinical symptoms present at birth, or developed early in infancy, or whether the blood serum reaction is the only positive finding, all do well under specific treatment. They gain weight, look happier, clinical symptoms rapidly disappear, and, in a large percentage, the blood serum reaction is reversed to a persistently negative reaction. The usual medications employed are the same as those employed in the adult—mercury, bismuth, and the different salvarsan preparations. Especially is sulpharsphenamine well borne by infants, and extensively used. All these drugs have one common objection, they must be administered by injection. Mothers instinctively

object to the use of the needle, babies are hard to control, and as they get older, there is a definite psychic reaction, which some carry for the rest of their lives. Also, the patient has to be brought to the office or clinic regularly, regardless of weather. In some cases, the expense attached to these treatments must be considered.

In 1924, acetarsone was first employed in congenital syphilis by Duperie, Cadenaule and Clarao. The first patients they tried it on were well-marked instances of congenital syphilis in infants. The good clinical results obtained encouraged them and other workers to give this form of therapy a further trial. On the whole, we can say that it is by far more gratifying in congenital syphilis than in any other condition in which it has been employed to date. The younger the infant when treatment is instituted, the better and more permanent the response. Especially are the results gratifying when patient is less than a year old.

There is a divergence of opinion as to the proper dosage. The total amount advised varies from 21 gm. in a period of 41 days (Tuscherer) to 14 gm. in a period of 49 days (Maxwell and Galser), while Abt and Traisman administer according to the infant's weight. They begin with 0.005 gm. per kilo of body weight, increasing the dosage gradually up to 0.02 gm. per kilo body weight daily. Their courses of treatment extend over 9 weeks, with a rest period of 6 weeks interposed.

We followed the simpler and safer plan of Maxwell and Galser. The patients were selected from our private office work only. The object was thus to have a better control over them, and be able to follow them throughout the entire time while under active treatment, and give them future observation. They were all under one year. Our instructions were faithfully followed in detail. We realize our inability to form a definite opinion as to the full value of this form of treatment, if we depend on our records only, as the number of cases under personal observation is by far too small. It is only when basing our judgment on the results obtained by other workers, as reported in the literature, and our own limited experience, that we can arrive at some opinion as to the real value of this form of therapy.

The mothers were given a detailed explanation of the object in view. Without exception, they were eager to coöperate, especially since the treatment obviated the necessity of weekly visits, and entirely eliminated needle injections. Stress was laid on the importance of early signs of toxicity; as fever, diarrhea, vomiting. Should any such signs appear, the mother was instructed to stop treatment immediately, and bring the baby for an examination. A morbilliform rash is common while the drug is being administered, and was considered as of no special importance. We classified this rash as a drug eruption, which disappears when the drug is stopped.

The dosage employed was according to the following schedule:

First week: ¼ gm. 0.25 tablet once a day.
Second week: ¼ gm. 0.25 tablet twice daily.
Third week: ¼ gm. 0.25 tablet 3 times daily.
Fourth week: ¼ gm. 0.25 tablet 4 times daily.
Fifth week: ½ gm. 0.25 tablet 3 times daily.
Sixth week: ½ gm. 0.25 tablet 4 times daily.
Seventh week: 1 gm. 0.25 tablet twice daily.

The tablets are easily administered by crushing them and suspending the powder in water, and are given half an hour before meals on an empty stomach. In all, 14 gm. are given, followed by a 6-weeks' rest period. The same course is repeated and, after the rest period, is followed by a blood serum examination. Should the result be satisfactory, i. e. negative, a similar amount of the drug is again given as was originally required to produce a negative serum reaction. Where the serum reaction is positive, the treatment is repeated as originally. Though we did not attempt to treat older children, there is no objection to its use. The drug is then administered for a greater number of courses, and bismuth injections given during the rest periods.

While the results are not as rapid as with neoarsphenamine or sulpharsphenamine, the few patients under our observation responded well to this form of therapy. The serum reaction was reversed to negative, and remained so for over 2 years of observation. The one patient with clinical symptoms, as hoarseness

and nasal discharge, cleared up after 6 weeks of treatment. Bearing in mind that the serum reaction may become positive at some future date, and clinical symptoms reappear, these patients are to be kept under observation for a long period of time, if possible until after puberty. Serum examinations are to be performed at regular intervals.

THE TREATMENT OF INFANTILE ECZEMA

Bart M. James, M.D.,
Newark, N. J.

The treatment of infantile eczema is probably one of the most perplexing problems the practitioner of medicine is called upon to manage. This is obvious when it is considered that the generic term—eczema—represents a variety of conditions with various etiologies. This, naturally, leads to confusion as to the type of eczema one is dealing with, as all types closely resemble one another clinically, and cause similar subjective symptoms, but are of different etiology and require different treatment. Also, regardless of the primary etiology, the development and clinical evolution of any skin lesion is aggravated by exposure to all kinds of irritants such as heat, cold, wind, dust, decomposed skin secretions, secondary infections, and excoriations caused by scratching. This constant exposure leads to many secondary pathologic changes, as is amply demonstrated in a typical case of infantile eczema.

Modern dermatologists consider that the majority of cases of *true eczema* are exogenous, primarily caused by substances which are not irritants *per se* but only act as irritants when brought in contact with the skin of hypersensitive persons. But there are certainly other types of eczematous eruptions in which the causes are probably of endogenous origin. This places eczema in the group of diseases of hypersensitiveness or allergy, and some types are associated with asthma, hay-fever and urticaria. This is further borne out by the fact that patients developing hay-fever, asthma, or neurodermatitis, have often had eczema during infancy.

Talbot and Towle were the first to consider infantile eczema to be due to excessive fat in the diet, and a consequent fat intolerance, and some of their patients improved with restricted fat intake. But if one examines a large number of patients with infantile eczema, it appears that most of them are not and have never been overfed. It is also true that decreasing the diet in general has a temporary beneficial effect. Schloss was of the opinion that eczema and asthma might be caused by a specific sensitization to foods or other substances, and might be detected by means of scratch-skin tests. Blackfan reported a series of cases of infantile eczema and found positive skin tests in about 60%. O'Keefe and Rackemann reported 239 cases with skin tests positive in 52%. Since then, many series have been reported with positive reactions from 50% to 80%. In substantiation of this work, several series have been reported in normal infants with a smaller percentage of positive results. Hill reported 132 cases of infantile eczema which were scratch-skin tested, with 57% positive, and in all the cases reported eggs, milk and wheat were the chief offenders in order. However, in Hill's series of the patients who gave positive results to eggs, 30 had never eaten eggs, and were not getting them through breast milk as they were bottle-fed. It is his opinion that skin tests are of possible value in about 50% of cases, but he also states that in many cases positive food tests are of little practical value, and that some reactions may not be specific at all.

One reason why a large percentage of positive tests are obtained is that the skin of infants is very sensitive, and frequently in cases of eczema dermagraphia is present. Most eczematous infants are bottle-fed and take no food but cow's milk. Therefore, if one accepts the endogenous theory as to cause, it is only fair to assume that a certain something in the milk is the responsible factor. Variot of France and Kerley of New York consider cow's milk protein as the chief offender in eczematous bottle-fed babies, and consequently advocated prolonged heating of the milk in order to bring about a change in the protein. Hill sub-

stituted soy bean flour for milk, with good results in a number of cases. In other cases he substituted evaporated milk with good results.

Breast-fed eczematous infants are usually fat, and improvement is likely to follow reduction of their food supply by dilution with water before or after nursing, but in these cases overfeeding is undoubtedly the main factor in causation of the eczema. Here again scratch-skin tests have shown about 60% positive tests to food that the mother is eating—mostly egg and milk, and occasionally to nearly all foods. The specificity of the tests is again open to question, because if the baby is weaned and placed on an exclusive milk diet, the eczema should improve rapidly. However, this does not always happen. As a rule, it is simpler and more advantageous to wean the baby rather than delete a large number of foods from the mother's diet, with a consequent ill-effect on the baby's general health. Peck is of the opinion that scratch-skin tests are of no help in many cases in tracing the etiology of eczema in children, but that patch tests are frequently of great importance. He also considers that foods, especially eggs, are of less importance than has hitherto been supposed. This confirms the work of Jadassohn of Breslau, Bloch of Zurich and others, who have shown that, as adult eczema is a disease of the epidermis, the patch test instead of the scratch-skin test, or intradermal injections, is the method which will give best results. This method differs radically both in technic and result from the other methods. The suspected substance for testing is applied to the unbroken skin for 48 hours, in contradistinction to allowing the substance to pass through the epidermis by way of scratch or injection puncture. Instead of the reaction appearing in a few minutes, it usually does not occur until 48 hours or even longer has elapsed. A positive reaction with the patch test consists of a papulovesicular eruption similar to the original eczema, or against the formation of a wheal and erythema in the scratch or injection tests.

Undoubtedly most cases of infantile eczema show polyvalent skin reactions to endogenous and exogenous substances. In other words, a baby's skin may be sensitive to external irritants such as wool, cotton, silk, and also be sensitive to milk protein or other unknown factors in milk. So there is, in some cases, a multiplicity of agents, endogenous and exogenous, which are provocative factors in making the condition chronic. Also, a great many patients have a peculiarity of constitution related primarily with the sympathetic nervous system and the blood vascular system, which Becker classifies as neurovascular instability.

It is necessary, in order to obtain good results in infantile eczema, to give great attention to details, see the patient frequently, and in the worst cases, hospitalize. Poor results in the worst cases can sometimes be attributed to failure to carry out instructions. It is imperative that the water intake be regulated, and usually increased in order that waste products in the form of urine and sweat will not be irritating to the skin. Acute infections, such as ordinary colds, tonsillitis and bronchitis, should be guarded against or controlled, as these have a tendency to aggravate or even cause a recurrence of the eczema. Furthermore, during acute infections there is a disturbance, as a rule, of the acid base equilibrium, with a consequent acidosis. The acidity of the urine and sweat is increased, with a deleterious effect on the skin. This condition can also occur as the result of teething, improper diet, or all 3 may be present at the same time. Therefore, the administration of alkalis is of value in infantile eczema and as a prophylactic measure. Needless to say, alkalis should be given only as long as it is necessary to stabilize the acid base mechanism of the body.

Pruritus of eczema. The intense pruritus which is a constant picture in infantile eczema must be combined by various measures. A few minutes of scratching will undo hours, and even days, of constructive treatment. It may be necessary to restrain the patient by means of tapes applied loosely to wrists and ankles and fastened to sides of the crib. Parents are inclined to believe that the above procedure is cruel, but as a matter of fact, after a while the baby is more comfortable and contented, due to lessened pruritus. All woolen clothing should be dispensed with, and a knit night-dress and diaper is all that is necessary provided the room is kept warm. Phenol ½%,

menthol ⅛%, anesthesin 2-4%, may be added to Lassar's paste for their antipruritic effect. In chronic eczema, crude coal tar has considerable value in allaying the pruritus. In more serious and obstinate cases, epinephrine 1:1000 solution may be given hypodermically in .1 to .3 c.c. doses. Ultraviolet light and x-rays may be used cautiously.

The most important factor in successful control of infantile eczema by local measures is the individualizing of cases in accord with the stage and clinical type of the lesions, degree and parts of the body affected and appearance of the secondary lesions. Eczema in its mildest form may consist of a slight scaly erythematous patch or patches which may show discrete papules or papulovesicles. In a more intense stage, the surface weeps profusely and, as the result of secondary infection, there is a formation of pus which dries on the surface into yellow crusts. As a rule, infantile eczema does not cause any constitutional symptoms, but very rarely sapremia or even septicemia may occur in pustular eczema. Also, in an extensive case, the different areas may be in different stages, so that a preparation which would be appropriate for an acute weeping patch would not be suitable for a more chronic and infiltrated area. In using local remedies, it must be explained to the nurse that the remedies must be in constant contact with the skin. This is especially important if salves are being used; and if a stimulating salve, such as tar, is used, the attendant should be instructed to rub it in gently and not merely spread it on.

Treatment of acute eczema. In acute weeping eczemas, as a rule oily and liquid preparations should be used. Ointments are interdicted because of interference with drainage and a possibility of the occurrence of acute infectious dermatitis as the result of damming up the secretions. Wet dressings of equal parts of lead acetate and aluminum acetate, Burrow's solution 1 part to 8 parts of water, are soothing, astringent, and slightly antiseptic. Applications of ether or silver nitrate 5% will often decrease the amount of secretions. As the inflammation and acuteness subside, soothing salves such as Lassar's paste, or boric acid ointment, may be used, to which appropriate antipruritic remedies may be added. If a large surface of the body is affected, an oily shake mixture, of which Pusey's calamine liniment is one of the best, may be used.

Treatment of chronic eczema. As the acute stage subsides and is replaced by the subacute and chronic stages, more stimulating remedies are indicated, as the skin is thickened and infiltrated and more resistant to treatment. Naftalan 5% to 20% in Lassar's paste or in zinc oxide ointment may be rubbed into affected areas twice a day, and a thick coating of the salve left on the skin at all times. The attendant should be instructed to remove the old salve with olive or almond oil before attempting to apply another coating. Crude coal tar 2% to 5% in Lassar's paste, or zinc oxide ointment, is probably the most useful remedy in chronic eczema. If the above ointment agrees with the skin, crude coal tar may be used full strength and painted on the various areas. If fissures are present, especially behind the ears, silver nitrate 5% solution may be applied. If the eczema is complicated by a pyogenic infection, ammoniated mercury 2% to 5% may be incorporated in the ointment.

Ultraviolet light therapy. Ultraviolet light therapy is of benefit in stubborn and intractable cases. It should be used with caution, in order not to provoke an erythema. Either the water-cooled or air-cooled modality may be used. The water-cooled burner is probably better because it is milder in action, and small circumscribed areas may be treated more easily. With the water-cooled burner, radiation only should be used and the burner never placed in contact with the skin. Suberythema doses are the maximum amounts given, which is sufficient to produce a mild stimulating effect. It is best to start at 12-18 in. skin distance for 1-2 minutes, slowly increasing the time. Two treatments a week are sufficient. The local remedies may have to be decreased in strength in order not to have too stimulating an affect.

Roentgen-ray therapy. Roentgen rays should only be used on patients not amenable to any other form of therapy. They have a beneficial effect on the pruritus and the thick infiltrated patches of chronic eczema. If x-rays are used, local irritating drugs should be replaced by

soothing salves such as boric acid ointment or Lassar's paste. It should be remembered that the x-ray is an extremely powerful weapon, which calls for caution and skill on the part of the operator, in combination with a knowledge of interpreting the morphologic changes in skin lesions. Subfractional doses 1/16-1/8 of an erythema dose are the maximum that should be given at weekly intervals.

Conclusions

There is no fundamental difference between the problem of infantile eczema and the problem of eczema in children, adults and old people. No single measure, whether dietary or local treatment, will be sufficient for prevention or treatment of the majority of cases. One reason for failure in infantile eczema in many cases is the stereotyped and uniform handling of cases, with total disregard to the cause and therapeutic requirements of the individual case. Eczema is a condition of the skin caused by a reaction to an irritant which may be single or multiple. Patch skin testing is of value in determining the incriminating agent in some cases, and if this fails, recourse should be made to other methods of allergic investigation.

The general health of the patient should be considered. While I believe that diet has perhaps been too markedly stressed, there is no doubt that some are benefited by elimination of certain foods, even though they do not give positive skin tests.

The practical management of a case of infantile eczema should include a study of the allergic reactions to foods, external substances, and skillful local therapy. Only by correlation of these can good results be obtained.

DIETETICS IN GASTRO-INTESTINAL DISEASE

Victor Knapp, M.D.,
Asbury Park, N. J.

It seems to me that a discussion of the dietetic treatment of organic lesions of the digestive tube will serve no useful purpose in our consideration of dietary. The fundamental principles of feeding patients with ulcer, cancer, gallbladder, and other pathologic affections of the gastro-intestinal tract, are generally accepted. Whether you prefer the Sippy, Lenhartz, von Leube, or modifications of these régimes, in handling ulcer patients, still, the basic use of frequent feedings remains unchanged. But it is in the dietetic therapeutics of functional dyspepsias that we meet a confusing diversity of opinion.

My remarks will be limited to this large group. Before embarking on the subject, a word defining the field included in this category of functional ailments is in order. Where the digestive symptoms are secondary to disease elsewhere in the body, or where they are part of a general disease, such as Addisonian anemia, our remarks will not apply. Obviously, this type requires primary attention to underlying pathology. We narrow ourselves down, then, to the large incidence of gastro-intestinal complaints in people in whom a thorough physical examination and laboratory study fails to reveal the presence of any pathology, but whose sufferings are none the less real, and often serious.

Not only does man not live by bread alone, but also, he does not digest by food alone. His habits of eating, sleeping, exercise and relaxation have a distinct and important bearing on his digestion. We cannot consider the subject of diet from the standpoint of food alone; all these factors must be kept in mind, always. I need not tell you that often it is these, and not the food eaten, that need correction. However, we must not forget that digestion is an involuntary act, and that it will take place whenever food is introduced into the digestive tube, regardless of the emotional state of the individual.

Sir Lauder Brunton has given, to my mind, the complete definition of man as differentiated from all other animals. He calls him the cooking animal; the only one who uses fire in preparation of food. And to this accomplishment much of our poor digestion is due. In many cases our culinary art has succeeded in producing a dish that appeals to our senses, but is all but impossible of toleration by the digestive tract. The food, not only of the ailing but also of the well, should be so prepared that

nothing is done to subtract from it its natural goodness, nor to add any substance that will render it either an inert or an indigestible mass. I have reference here to the frying and preservation of food; frying envelopes the aliment in a film of indigestible fat, while an irritating aldehyde, acrolein, is formed in heating fat to the necessary high temperature.

The preservation of food, with its effect on digestibility and biologic value, requires some discussion. Drying and canning of fruits and vegetables is undoubtedly the best means we have of conserving these foods. However, the heavy syrup used in preservation of fruits is not to be recommended as a suitable aliment in a regular diet. But when we consider animal foods, we come to pickling, smoking, salting, and all the other methods used in an attempt to keep them from spoiling. As soon as the source of life of plant or animal is cut off, that animate thing begins to decompose. The higher the scale of life, the more quickly does this decomposition set in. In fish, it starts even more rapidly. Any means which we have at present, with the possible exception of rapid freezing and refrigeration, does the work inadequately, from the viewpoint of digestibility and biologic value. The result is that when a practice is made of eating preserved meats and fish, digestive upsets are invited. The diet we prescribe for the dyspeptic must exclude them. Wherever possible, fresh foods must be used.

In the older literature, a great deal of attention was paid to a variety of functional secretory derangements of the stomach. Hyperacidity, continuous hypersecretion, hypo-acidity, gastric catarrh, and such, were all described, and a train of symptoms given as diagnostic of these aberrations of function. Of late, we have been getting away from this classification, in the light of newer and better understanding of the functions of the gastro-intestinal tract. It is safe to say, now, that the degree of acidity of the gastric juice is of little moment. What we are interested in is its presence or absence, and not the amount. Where it is absent, and the patient apparently well except for functional dyspepsia, we are faced with the problem of interpreting these findings as a congenital achlorhydria, which is found in 4 out of every 100 individuals; or looking upon it as a pathologic entity. Only time will tell the bearing this anacidity will have on the afflicted one's life as he grows older. Its presence does not affect the dietary prescription, though it does the medication.

Symptoms of poor digestion, such as fulness after meals, uncomfortable fulness, I mean, pyrosis, belching, abdominal pain, and globus hystericus, are found in patients giving every variation of acid curve. Their dietetic treatment is identical. The illuminating work of Alvarez, on gastro-intestinal physiology, has given us a new understanding of the production of these symptoms; and his contention that they are all motor phenomena, due to reversal of gradient, is fascinating and probably correct. I have found that the use of the smooth diet he recommends answers the purpose of effecting relief in functional dyspepsia, if it is truly a nonorganic condition.

One of the most difficult problems in dealing with this class of patients is to get them to eat. Usually they have, either voluntarily or on advice, eliminated practically every article of food from their diet. We find them possessed of a real phobia for food, and it is hard to get them back on an adequate diet. Our first and most important duty is to prescribe an adequate diet, and all that this implies. Too many patients are of the opinion that to diet is synonymous with partial starvation. Invariably, the dyspeptic has been made so as the result of bad habits. We must teach him good habits. He must be impressed with the fact that no food is in itself a health food, and that a rational variety of food every day is what will make him better.

Meat has stood the brunt of attack in dietetics. It has been accused of fostering not only digestive, but also cardiorenal vascular disease, so-called rheumatism, arthritides, etc. Whatever truth there may be in this accusation in regard to other conditions, there is no gastro-intestinal functional derangement in which meat is interdicted. This, of course, assumes that it is fresh, and properly, which means hygienically, cooked. The proteids of meat are more readily digested, and place less of a load on the digestive organs, than do those of vegetables. As Alvarez has pointed out, man was

a hunter and fisherman before he was a farmer, and his digestive apparatus is better equipped for the digestion of animal food. Yet we find the dyspeptic attempting to overcome his disability by eschewing meat and subsisting on a vegetarian diet. That some can get along fairly well on a restricted vegetarian régime cannot be denied. Read is of the opinion that such people are exceptional, and may be regarded as arrested in evolution, or reversions to a primitive type. In the late war an excellent opportunity was afforded to observe what a diet deficient in meat can do. Adequate nutrition of the adult calls for animal protein. There is a quality in animal protein that stimulates cell life and function, and promotes physical and intellectual development. That such a valuable food-stuff need not be denied the dyspeptic, is to be borne in mind.

Functional gastro-intestinal complaints cannot be said to arise as the result of poor function of either the stomach or bowel alone. Necessarily, if the stomach performs its work unsatisfactorily, the remainder of the tube must suffer. It will profit us to consider the large bowel now, and say something about so-called constipation. I say "so-called" advisedly, for I agree with Soper that no one can assume to state when the intestinal content should move forward. The obsession of doctors, in common with laymen, that the human colon is a sewer which should be kept flushed out, has its roots in the oldest medical writings extant. The ancient Egyptians were so impressed with the importance of flushing out their bowels that they did so regularly 3 times a month, and took an emetic at the same time, to make a thorough job of it. We haven't unlearned the folly of such conduct yet! While it is true that the bowels should move, on the average, once a day, there are people who normally have no need for one more often than once or twice a week, and even less often, and suffer no ill effects. Authentic cases have been reported where no bowel movement has taken place for months at a time, with no illness, and surely with no symptoms of so-called auto-intoxication.

The mechanism of the bowel, like that of every structure of the body, is finely adjusted, and it takes little to derange it and bring on symptoms. Inordinate taking of cathartics, administration of enemas, and partaking of excessive quantities of indigestible foods and grasses can do no good. The alimentary canal has no ferment for the digestion of cellulose, though Lohrisch thought he found one in the cecum. The presence of cellulose in the digestive tube hinders the digestion of starches and leads to excessive fermentation, with the production of abnormal quantities of gas, a symptom practically all dyspeptics complain of. There is no good reason for overloading the intestine with indigestible roughage in an attempt to gain more voluminous movements. The smooth diet accomplishes the task of restoring normal bowel physiology in many cases.

That the symptoms usually ascribed to constipation are not due to toxic absorption from the bowel has been proved beyond doubt. In fact, the patient with diarrhea really suffers from such intoxication, for his bowel is congested and inflamed, and its natural defenses are in abeyance and allow absorption through the bowel wall to take place. No absorption of toxins is possible from the intact, normal bowel wall. But the irritation produced by catharsis, with its consequent liquefaction of the stool, makes for an ideal combination of circumstances in favor of absorption. The well formed, hard stool, in a normal bowel, is our best protection against absorption. It is true that after evacuation, the patient suffering from lassitude and malaise, resulting from retention of intestinal residue beyond its normal time for elimination, feels better immediately. It need hardly be pointed out that were these symptoms the result of absorption of toxins, prompt relief from a bowel movement could not occur. The truth is, the symptoms are the result of distention of the rectum, as shown so convincingly by Alvarez; and one needs but empty the distended rectum to effect relief.

As has been intimated, the diet which answers the problem of what to feed the patient with a functional gastro-intestinal complaint, is a bland or smooth one. It is a well-balanced diet, one that supplies a biologic variety of vitamins, minerals, fats, carbohydrate, and protein. I may repeat that you must never forget to feed the dyspeptic foods of good

biologic value. Any one-sided plan means an unbalanced regime, and is compounded of deficiency in association with excess; for example, a deficiency of vitamin B with an excess of starch.

Faulty foods have their first deleterious effects on the gastro-intestinal tract. McCarrison has pointed out, in his extensive study of the food habits of man, that the dyspeptic eats a dangerously deficient diet, lacking in vitamin content, and in protein of good biologic value, and disproportionately rich in carbohydrates and fats. In fact, the food is that most calculated to promote the very disorder from which he seeks relief. Faulty food habits are twice as common as lack of adequate food. It is to man's disgrace that he has quickly taken to the application of known dietetics to his live stock, but has neglected to use this knowledge to his own health advantage. Isn't it a sad commentary that a thoroughbred horse, fed on exactly the physiologic proportions and variety of food, will sell for a greater sum than the average white-collar worker earns in a year?

I tell patients who have indigestion that they may eat everything, with reservations. These exceptions do not include any variety of edible food, but rather its preparation. This assures a biologic dietary, and one that not only serves their needs, but conquers their indigestion. Let us recall that a while ago I mentioned that the amount and kind of secretion the stomach is manufacturing, aside from the presence or absence of acid, does not concern us in outlining diet. We have assumed that the symptoms are due to alterations in motor function, and that the normal downward gradient of the digestive tube has been disrupted by some irritant, which is a combination of faulty food and antihygienic habits. In spite of the disturbed motor forces, a smooth diet, with little residue, and which is easily liquefied, will traverse the tract with little, if any, trouble. Alvarez cites the experiment in which segments of an animal's intestine were reversed. As long as a liquid diet was fed to the animal, he lived; but as soon as solid matter was given, death from intestinal obstruction ensued. While the liquid food could pass the reversed segments, the solid food was held up.

Those foods which contain an abundance of roughage, such as cabbage, celery, peppers, cucumbers, raisins, the skins of fruits, and berries, are not allowed to the dyspeptic. Aside from catering to the disturbed gradient in the person with indigestion, such dietary restriction takes into account the absence of a cellulose-splitting ferment, and the interference with starch digestion exerted by the presence of large amounts of cellulose. Fried food is not permitted for reasons already stated. The same applies to preserved meats and fish, as bought already prepared at the delicatessen store. Even were the freshness of such foods beyond question, the inordinate amount of spices used in their preservation makes them unacceptable. These spices act as irritants. Candies, ice cream, pastries, and sugar in other concentrated forms are interdicted, because their high concentration marks them as irritants, and less of the protective foods will be eaten where sweets are indulged in.

Coffee-drinking is a moot question. I do not think the caffeine content has anything to do with forbidding coffee to dyspeptics. The average cup of coffee contains but 1 or ½ gr. of caffeine. Few people drink enough of it to get any caffeine stimulation, much less caffeine poisoning, unless an idiosyncrasy for the drug exists. In September 1928, the chemical laboratory of the American Medical Association published its results of an investigation of the better-advertised caffeine-free coffees. It found that when the beverage was prepared as advised on the container, the amount of caffeine in each cup of coffee was about the same as that of coffees not advertised as decaffeinated. To my mind, the objection to coffee drinking lies in its preparation. Percolating is the common method. It is lost sight of that all we want of coffee is its pleasant aroma and taste. Both are obtained by pouring boiling water over the coffee grounds just once, as is done in the drip method of preparation. Repeated extraction of the bean by boiling water, as in percolation, removes from it irritating aromatic oils, tannic acid, and coffee wax; all objectionable products. The single extraction of the drip method brings down a minimum of these products. Coffee prepared in this way is allowed the dyspeptic, and ap-

parently does not affect his recovery, and at the same time allows him a beverage which he really enjoys. This is by no means the accepted opinion, or even one held by the majority, concerning not only coffee, but dietetics as a whole. It must be remembered that dietetics is not an exact science.

The patient, then, is allowed to eat meat, chicken, fish, soups, eggs, milk, cooked cereals, cooked fruits, cooked vegetables, plain desserts as custard tapioca and gelatine, and coffee, tea, or cocoa in moderation. Individual cases demand individual attention, and the diet suggested is used only as a working basis, to be altered as indicated. Where the patient is underweight, he is encouraged to use considerable sweet butter and sweet cream. Olive oil helps many, if they find the oil not objectionable to take.

A discussion of the use of alcohol and nicotine in the dyspeptic would take up more time than we have to give to it. In general, it may be said that neither serves any particular indication in indigestion, but that an occasional drink of an absolutely pure alcoholic beverage is not to be frowned upon. As for smoking, nicotine has a definite bad effect on the vagus, and consequent interference with digestion. Where possible, it should be discontinued, and in all cases, reduced as much as possible.

For patients who complain that they are constipated, I do not prescribe roughage. I disregard the complaint, and ask them to report to me if they haven't had a bowel movement in 2 or 3 days, without having used any cathartic or enema. Then, if they are much concerned over their apparent constipation, and believe they are being discomforted by it, I instruct them to take an enema, using from a pint to a quart of warm physiologic saline, which is easily made by adding a teaspoonful of common salt to a pint of water. I have found that as soon as the patient is convinced that no harm is done to him by going a few days without an evacuation, normal daily movements will begin in a short time. We must not forget that we are dealing with patients who have not only partially starved themselves, but have also resorted to repeated and constant cathartics, in an attempt to overcome their indigestion. So we must feed them well, and see that they do not waste all our good feeding by taking cathartics and getting rid of the food.

Lest it be thought that reliance on diet alone in the treatment of these patients is all that is used, I hasten to add that every other form of therapy is employed as indicated.

In closing, 2 quotations from McCarrison are pertinent. He says that: "In the fascinating pursuit of pathogenic organisms as a cause of disease, we are apt to overlook the claims on our consideration of sufferers from non-infectious maladies; the claims, for instance, of the dyspeptic. But such maladies, by impairing the vitality of the sufferer, prepare the field for microbial infection." And he makes the melancholy, and yet wholly accurate, remark that: "We seem to be more salvagers of wrecks than pilots whose function it is to avert them."

MEDICOLEGAL ASPECTS OF BONE INJURY

Max Kummel, M.D.,
Member, New Jersey Bar,
Newark, N. J.

Modern civilization has conferred on us the blessings of improved health and physical well-being but has also created the very instrumentalities to deprive us of its benefits. It has multiplied life's hazards from flying planes, speeding automobiles and complicated machinery. Their yearly toll of peacetime victims exceeds our honor roll of the World War. Fortunately, many of the injuries sustained involve the superficial structures and heal without evil after-effects. However, among the less fortunate of the group, the trauma is more severe, pain and suffering more intense, the pathology extends to deep structures, temporary incapacity is more prolonged and permanent disability greatest. Injuries of this type invariably involve the bones, joints and, most frequently, a combination of both.

The pathology of injured bone is based upon a knowledge of its normal structure, its process of repair, and its deviations, when physio-

logic repair does not occur. Under ideal conditions, regeneration of bone takes place in the orthodox manner and the injured bone is fully recovered. However, under unfavorable circumstances a pathologic process replaces physiologic repair and, as a result, there is little or no repair, sometimes a progressive degenerative process, and occasionally a malignant transformation.

Bone is one of the hardest structures of the human body. It consists essentially of 2 kinds of tissue: (1) compact tissue placed on the exterior, hard and ivory-like in texture; (2) cancellous tissue, occupying the interior and consisting of slender fibrillae and lamellae which join to form a reticular network. The relative proportion of these tissues varies with the different bones and with the different parts of the same bone in accordance with its function. Thus, since the middle of the shaft of a long bone is its weakest point, and since it is called upon to support heavy weight, nature provides for this by reënforcing the weak point with an increased amount of compact bone.

Periosteum is a fibrous membrane covering the surface of bone and consists of 2 layers closely united, the outer formed chiefly of connective tissues and the inner of fine elastic fibers, forming a dense membranous network. Between the inner layer of the periosteum and outer layer of the bone proper is a layer of soft tissue containing granular corpuscles or osteoblasts, by which ossification proceeds to the exterior of young bone. The periosteum is the passageway for vessels going into the bone, and is very vascular in the young but grows less so in the old. Arteries, veins and nerves are fairly distributed through it and accompany the nutrient artery into the medullary cavity.

The interior of the long bones of the limbs presents a cylindrical cavity filled with marrow and lined by a vascular lining called the medullary membrane. This marrow extends through the spaces of the cancellous bone into the longer bony canals (Haversian) which contain the blood vessels. It varies in composition. In the shafts of the long bones, it is yellow in color and consists mostly of fat and some marrow cells. In the short bones and articular ends of the long bones, as well as in the vertebrae, cranium, sternum and rib, the marrow is red, has some connective tissue elements and numerous blood cells.

Repair of injuries to the skeleton differs in one respect from repair of other tissues; in the latter, healing is essentially dependent on the formation of a fibrous tissue, while injured bone, under favorable conditions, reproduces bone. A few days after an injury or fracture, all the connective tissue around the traumatic area becomes edematous and swollen. There is a multiplication of the fibrils and the formation of a network which is the essential framework of future columns of bone. Into this prepared connective tissue network, there occurs an infiltration of a viscous resistant preosseous substance, sometimes called "osteoid tissue". The lines which it forms assume the arrangement of the bone trabeculae. Almost immediately after their appearance, the lines of the connective tissue latticework are infiltrated in the center with calcium salts, which render them hard. For our purposes, it is sufficient to state that the osteoblasts in the subperiosteal layer mentioned above are connective tissue elements of some sort, which have acquired, by an indefinite mechanism, the capacity to secrete bone substance.

It is well to remember that a process akin to repair is continually going on in the human bones, for in spite of their firmness, rigidity and apparent unchanging composition of the completed osseous tissue, there is a physiologic, internal, never-ceasing change in the bones, not only in the growing individual but in declining age as well. On the one hand, there are destruction and resorption of the finished bony tissue; and on the other hand, there is a replacement of new osteoblastic tissue soon to be calcified and matured. In the young, the process is rapid and growth greater than destruction; in adults, the combination is apparently well balanced; in the aged destruction is greater than growth.

Nature, ever vigilant in its protection, has avoided the inherent weakness of straight lines and sharp angles in the gross structure of bone. It may be stated that this is true not only of each bone individually, but that the human body as a whole is of the best possible shape

and structure to withstand the various traumas of every-day life. Bones are provided with the further protection of: (1) Thickness of overlying structures. Things being equal, a given force would cause more damage to anterior surface of the tibia than to the posterior, because of the buffer action of the thick hamstring muscles. (2) Mobility of the overlying structures. This mitigates against injury. Even though it lacks thickness, the freely movable scalp is a protection for the skull against injury. If any force is applied to the head in any direction, except at right angles, the scalp slides and diverts the violence. (3) Range of mobility of joints. The mobility of a joint tends to protect the bone against fracture by partially removing the element of counterforce—1 of the 2 essential factors in causation of injury (force and counterforce). (4) A bursa over a bone. This confers the same protection on the underlying bone by its cushion effect. This is best exemplified by the bursae over the patella and olecranon process.

It is almost axiomatic to assume that there are 2 sides to a story of a contested medicolegal case. With the aforementioned considerations in view, the alert examiner might be able to determine and enlighten the court as to whether a given injury was caused in the manner alleged by one or the other of the contending parties. Furthermore, with a knowledge of anatomic structure, physiologic process during life, and repair, and pathologic deviation under unfavorable circumstances, the careful physician should be able to recognize the character of residual damage and prognosticate the extent of the permanent disability arising out an alleged injury.

Inflammations. According to the situation of the process, or as to whether the brunt of the inflammation falls on the periosteum, bone tissue itself, or bone marrow, we speak of periostitis, osteitis and osteomyelitis. Their line of demarcation is merely academic, since an attack of periostitis generally involves the outer aspect of the bone proper, while osteitis is really a form of osteomyelitis in which the inflammation arises first in the vascular canals of the spongy or compact tissue. When the marrow tissue which lies in the canals becomes involved, and spreads, we have osteomyelitis.

Traumatic periostitis is an inflammation of the periosteal membrane caused by external violence, manifesting itself in various forms. Traumas such as contusions, pressure, or sudden pull with a partial detachment of periosteum at the site of muscular attachment, may produce a circumscribed cicatricial thickening of the periosteum, which develops as a soft painful exudative swelling, and which subsides rapidly, although tenderness, pain and even thickening may persist for a long time. Occasionally, a chronic periostitis, with a periosteal thickening and peripheral osseous new growth, may follow trauma. This forms an ossifying periostitis, which may lead to an exostosis with abnormal bone formation or a synostosis between 2 neighboring bones, such as tibia and fibula or 2 neighboring vertebral bodies. Frequently, pyogenic organisms (pus) reach the periosteum through an open wound, or take advantage of a local lowered resistance caused by blunt trauma, and collect in the internal periosteal layer, thus lifting off the periosteum. This process may terminate in one of several ways. It may rupture externally and heal with cicatrization. It may invade the surrounding soft tissues and produce a phlegmon. Or, finally, the purulent periostitis may cause exfoliation of superficial layers of bone and cause an osteitis or, by cutting off nutrition, cause necrosis and caries and transform into an osteomyelitis.

Traumatic osteomyelitis may be considered to include all the inflammatory conditions of bone and their sequels arising out of infection and resulting from injury. It may result from direct infection, from a penetrating wound and compound fracture, or indirectly through lowering of local bony resistance and subsequent invasion of microörganisms by the blood stream. The disease consists of an infection in the medullar tissue; the products of inflammation cannot be accommodated in the unresisting bone, and the areas of bone become devitalized either by the injury itself or the infection which follows, with resulting necrosis. Sometimes the entire shaft becomes necrotic, may be spontaneously detached at its epiphysis, and float in pus beneath the unruptured periosteum. Usually, before this state is reached, drainage is instituted by operation

or spontaneous rupture through the periosteum. The latter is raised from the cortex, and new subperiosteal bone is formed which proceeds to envelope the sequestrum (devitalized necrotic bone). The new bone layer is at first soft and plastic, but later becomes dense or sclerotic, and is known as the "involucrum". The pus bathing the sequestrum is discharged to the surface through orifices in the involucrum, called "cloacae". It generally requires considerable time before the dead bone can be separated. However, the osteomyelitic lesion does not heal until the sequestrum is extracted or removed.

As for consequences and legal significance, "Once an osteomyelitis always an osteomyelitis", was said by one author. While healing without bone destruction after resorption of the inflammatory exudate is still possible, it is rather remote and improbable. Theoretically, if the sequestrum is removed while the involucrum is still plastic, the cavity left will be filled up with new bone and result in perfect recovery. Practically, however, the sequestrum remains longer, the involucrum loses its regenerative power and becomes dense and sclerotic, the generalized symptoms subside and the process localizes at or near the site of injury, leaving a weak and painful bone.

The general sequels are as follows:

(1) Death may follow shortly after the onset from a severe generalized pyemic infection; or many years later, from amyloid degeneration of the internal organs, particularly heart, lungs, liver and kidneys.

(2) Metastases from infected foci may be manifested in other bones or lodge in the internal organs, reducing general efficiency and causing recurrent periodic incapacity.

(3) Chronic discharging sinus. There is established a chronic evolution of new sequels, new abscesses, new fistulas, extending over a number of years, which, by continually draining the vitality, brings about a lowering of resistance, thus rendering the victim an easy prey to intercurrent disease.

These are the local sequels:

(1) Bony abscess (Brodie's). As a result of a subacute osteomyelitis, a small localized abscess may form, which is confined by a dense wall of sclerosed bone, and may remain latent for many years, causing intermittent pain, limping, and later an enlargement of the bone. It generally occurs in the middle of long bones, most frequently in the tibia. Sometimes this abscess drains itself spontaneously by rupturing through the bone and soft tissues, leaving a discharging sinus.

(2) Ankylosis—stiffness of the joint above or below the lesion by direct extension of the destructive process within the joint, or by muscular spasm or adhesions outside the joint.

(3) Porosis. There is a melting of bone, whereby the compact tissue becomes porous and weak.

(4) Sclerosis. The bone becomes dense, canals become narrowed, and the contained nerves are pressed upon and cause pain.

(5) Atrophy of bone—actual diminution and shrinkage in size of bone, chiefly as a result of inactivity or disuse. Atrophy may also be due to pressure from interference with bone nutrition.

(6) Deformity—throwing the extremity out of its normal axis, thus interfering with its physiologic function.

(7) Miscellaneous — ultimate incapacity caused by pathologic fractures, complicating overlying soft tissue infiltration, gangrene, amputation, etc.

(8) Osteitis deformans (Paget's disease). This disease consists of a replacement of normal bone by a more massive and less dense bone. It has been described as an "osteoporosis or spongy hypertrophy of bone". It consists of a destruction of old bone with an excessive production of new but non-calcified bone. It is a disease of middle age or later life, and appears in 2 types: (1) multi-osteal, which attacks many bones, particularly the long bones and skull, and (2) mono-osteal, in which a single bone only is affected, usually the tibia or femur. It is the latter form which may precede or follow a fracture, and which often gives rise to a dispute as to its relation of trauma. However, since the cause of the disease is unknown, it is difficult to state whether trauma was the proximate etiologic factor in its causation, or merely called attention to its presence, or actually aggravated a dormant preëxistent condition.

(9) Osteitis fibrosa cystica (Von Reck-

linghausen's disease) is a chronic disease characterized by fibrous transformation of the marrow, often by cyst formation by expansion, weakening and deformity of the affected bone. It is a disease of adolescense; usually begins before the age of 20; its pathologic process is closely related to Paget's disease and its relation to trauma similar but more remote. When the process is confined to one bone, it is limited in nature and usually cystic in structure. Such a localized process may be induced by injury. It is interesting to note that not infrequently, when a fracture takes place through a cyst, not only does the fracture reunite but the cyst is cured in the process.

Rarefying osteitis. There is a group of diseases of bone rarefaction of traumatic vasomotor origin, closely related, presenting certain elements of similarity, in which trauma plays a prominent rôle. These diseases assume different names in accordance with the bone involved or the name of the author who first described the disease.

(1) Kummell's disease—traumatic spondylitis. This is a rarefying osteitis of the vertebrae, which develops after injury to the back and gives rise to a gradually increasing kyphosis. It is in all probability the result of compression trauma, and represents an end stage of unrecognized compression fracture of the vertebral bodies, with delayed symptoms and deformity. It generally manifests itself after a period of apparent improvement, by pain and weakness in the spine and sensory and motor disturbances in the legs. Prognosis is unfavorable.

(2) Kienbock's disease. This is an isolated osteitis of the semilunar bone, occurring most frequently in the right hand of male manual workers. A severe trauma of the hand or wrist is not essential, since it may be a trauma so light that the individual rarely stops work on account of it. The usual history elicited is a fall on the dorsally flexed hand, slight symptoms for a few days, a comparatively symptomless longer interval, and finally an acute recurrence with severe pain over semilunar bone. The pathology probably depends on interference of blood supply through an injured ligament. X-rays show no apparent damage in the early stages, but some months later reveal its characteristic changes of bone compression. Unless attended to, this condition gives rise to pain and marked loss of function.

(3) Kohler's disease—tarsal scaphoiditis. This is an osteitis involving the tarsal scaphoid only. It is limited to the developmental period most commonly in boys between the ages of 3 and 10. In many instances trauma is the exciting cause. However, a careful history may disclose that the beginning of the process antedated the trauma, which merely acted as a provocative aggravating agent. X-rays show the area of ossification smaller than normal, while examination of a specimen reveals an inflammatory necrotic zone in the bone, the marrow replaced by fibrous tissue. The symptoms are generally transitory, the condition tends to disappear spontaneously.

(4) Osgood-Schlatter's disease—separation of the tibial tubercle. This consists of a partial separation or complete avulsion of the tibial tubercle from the shaft of the tibia. This may be brought about by direct injury to the tubercle, or indirectly by strain or sudden pull on the quadriceps extensor muscle, which has its point of attachment on the tubercle. It appears commonly in boys between the years of 10 and 15, before the epiphysis has become completely ossified, and under sudden strain the weak cartilaginous attachment may easily give way. Disability varies from local discomfort to extreme pain and limitation of motion; frequently the pain is augmented by an associated bursitis arising out of the same injury. X-ray examination shows a definite space between the tubercle and its osseous attachment.

(5) Legg-Perthe's disease—osteochondritis deformans coxae juvenalis. This disease is characterized by a flattening of the upper epiphysis of the femur, and appears in early life, between the fifth and tenth year, and is not seen after the fifteenth year. Legg believed that trauma caused a disturbance in the circulatory relationship between the epiphysis and the femur, producing an atrophy of the epiphysis through diminished blood supply, and an hypertrophy of the neck from increased blood supply due to a blocking of the latter. The condition begins with limping, moderate abduction, and apparent lengthening of the leg.

There is slight atrophy and limitation of the extreme motion, particularly in abduction and inward rotation. The diagnosis is confirmed by x-ray examination, which shows characteristic changes. These consist at the beginning of an irregularity in the epiphyseal line and, later, a general breaking-up and flattening of the head of the bone. Functional recovery is the rule in the majority of cases, although in many the symptoms and disability persist through life.

Tuberculosis. Primary tuberculosis of bone is exceedingly rare. It is generally always secondary to a tubercular lesion elsewhere, mainly in the lymphatic glands in children and lungs of adults. It is generally believed that tubercular bacilli gain entrance to the body through the tonsils, respiratory and alimentary tracts; are sifted through the lymph glands; and are eventually carried into the blood stream until they are destroyed or find a location favorable for their growth. Trauma may not only be a predisposing factor for the localization, but also is able to stir latent tuberculosis into activity. Injury, such as contusion of bone, acts as an exciting cause for the lodgment of the tubercular bacilli, by lowering local resistance to the invading organism.

The end-results of bone tuberculosis are as follows:

(1) Tubercular foci in bone may heal spontaneously, by a process of fibrosis, especially in well-nourished children.

(2) May develop a cold abscess.

(3) Suppuration, with chronic discharging sinuses.

(4) Extension into adjacent joint.

(5) Indirect danger to life from dissemination to vital organs.

(6) Direct danger to life varies with location and bone involved. In disease of the spine, it may involve the cord or extend to important organs in the neighborhood.

Syphilis. Syphilis is another disease in which trauma may be a causal factor in aggravating or flaring up a latent process into activity. Much of the present-day importance of the subject is due to our more advanced knowledge and recognition of the great number of unrecognized syphilitics in our industrial communities, and the effect of trauma upon them. The tendency of infectious disease to react to trauma by an exacerbation is also characteristic of syphilis but not as dramatic in its manifestations. This is particularly true of hereditary syphilis, or the acquired tertiary type, where the individual was never aware of its existence or had already forgotten its initial presence.

Primary syphilis of bone is rarely encountered in traumatic practice. A careful search usually reveals a primary lesion, and appropriate treatment provides the therapeutic test. The latter is of more significance than the x-ray or Wassermann, because the former is not characteristic and the latter is frequently negative in syphilis of bone. Even apparently insignificant injuries, such as contusions and bruises of bone that, otherwise, would have little importance, in the presence of syphilitic infection may become the starting point of pathologic processes which frequently cause prolonged disability and permanent incapacity. Superficially placed bones, especially the tibia, are affected most frequently, because they are so often exposed to injury.

The time relation between occurrence of the injury and development of syphilitic changes is of great importance from the medicolegal viewpoint; where the specific lesion appears from 3 to 6 weeks after the accident, it will be regarded as the result of injury. However, in tertiary syphilis we know that the changes are more gradual, and require a long time to develop; the establishment of a claim would rest entirely upon slight but persistent symptoms which "bridged" the interval between injury and diagnosis.

The consequences of syphilis of bone are similar to those of tubercular infection. Gummas develop which may remain quiescent, undergo caseation, or become infected with pyogenic organism, with resulting suppuration. These gummas weaken the bones by a process of rarefaction, and as a result spontaneous fractures may occur.

Tumors. (1) Benign. Pure bone tumors, particularly those following trauma, are benign in nature. The hyperostosis developing about bone injury is usually composed of dense bone, even of ivory-like density. Exostosis, or osteoma, usually arises from overgrowth of subperiosteal bone, and must be

attributed to irritation of a fragment of periosteum or fracture caused by injury. In cases of this nature, trauma is often claimed and seldom proved. However, these tumors usually cause no symptoms other than discomfort and are not followed by disabling after-effects. Cystic tumors of bone may also occur from traumatic causes, inasmuch as hemorrhages produce a secondary rarefying and ossifying osteomyelitis.

(2) Malignant. It is generally accepted that carcinoma is never a primary disease of osseous tissue, but is apt to attack the bones by metastasis from a cancer elsewhere in the body. A single local trauma in the nature of a bruise, sprain or fracture may be the direct exciting cause of sarcoma, especially in the long bones. It is the mild bruise or contusion, rather than the severe fracture, that is apt to be followed by sarcoma. In Coley's series of 360 cases of sarcoma of the long bones, 181 showed a definite history of antecedent local trauma. The prognosis is grave, since almost all sarcomas of bone eventually prove fatal.

Industrial disease. (1) Phosphorus poisoning (phossy jaw) is an industrial disease caused by the local and general absorption of the fumes of phosphorus. It occurs in match factories, in individuals who have worked for a number of years, chiefly anemic individuals, and is most marked in those having carious teeth. This process generally starts in a carious tooth, which it loosens, penetrates the periosteum, and, because of the constant presence in the mouth of suppurative organisms, results in a suppurative periostitis. The teeth fall out, abscesses form, an ossifying periostitis develops, to end in necrosis of the jaw and separation of the bone. If the lower jaw is afflicted, there is an attempt at repair by an active proliferation of periosteum and the formation of callus, at the same time with the formation of a sequestrum. In the upper jaw there is little or no effort at repair, and the dead bone usually comes off in fragments. As a rule the pain is intense, the destruction extensive, and disability pronounced. Fortunately, as a result of education and legislation, the use of white phosphorus in the manufacture of matches has been prohibited and the occurrence of the disease eliminated.

(2) Lead poisoning. Lead, when inhaled or ingested, is stored nearly completely in the bones, where it is carried by the circulation. The effect of lead poisoning upon the skeletal system has been summarized by Joseph C. Aub and his associates as follows: "There is a selective localization of lead in the calcareous portion of the bone, where it is stored as the very insoluble tertiary lead phosphate. Under normal conditions it may remain inactive for long periods of time, but an alteration toward the acid side of the usual hydrogen-ion concentration of the organism, may liberate the stored lead, probably by transforming the tertiary lead phosphate into the much more soluble secondary lead phosphate."

No untoward consequences or incapacity have been shown to arise out of this lead storage. Although it has been claimed that the lead stored in the bones of the developing child interferes with its growth, there has been no clinical or experimental evidence produced to substantiate such deleterious effects. However, owing to the parallel metabolism of lead and calcium, and because both metals are held in the body at a common site, an injudicious program of de-leading by medication, tending to increase the calcium excretion, coupled with a deficient calcium intake, may lead to osteoporosis with its complications.

(3) Radium and mesothorium. The effect of radium poisoning on bones resembles phosphorus in its local manifestations of jawbone necrosis; it resembles lead in its general manifestations of storage in the various bones and its liberation by a process of increased calcium excretion, coupled with a low calcium intake. In the New Jersey radium dial painters, the mode of poisoning was chiefly by ingestion, and to a small extent by skin absorption and inhalation. Owing to a general habit among the workers of pointing their brushes in their mouths while painting their dials, they swallowed small amounts of radio-active paint day after day. The process generally began with inflamed gums, gradual breaking down of tissue around the teeth, radiation osteitis of the jaws and, because of the ever-present bacteria in the mouth, an extensive necrosis of the mandible and maxilla. It is at this stage that it resembled phosphorus poisoning, was treated

as such by some dentists, and in one case the hospital diagnosis read "Chronic osteomyelitis of the jaw, possibly due to phosphorus poisoning".

Those patients who survived the early stages escaped the extensive necrosis of the jaw and associated severe aplastic anemia and, after several years of apparent good health, began to develop chronic crippling bone lesions. The latter were in the nature of radiation osteitis, most marked in bones that are subject to weight, pressure and trauma, such as head of the femur, acetabulum, spine, pelvis and tarsal scaphoid. Shortly thereafter, spontaneous fractures occurred in some, which, upon roentgenologic examination, disclosed an osteogenic sarcoma. This was corroborated by autopsy in a number of cases. During one of the Tuesday evening conferences at the Newark City Hospital, Dr. Martland demonstrated a case of multiple primary sarcomas, scattered through various bones, caused by radium poisoning.

Fractures. A fracture is the breaking of a bone. The break may occur at the point of impact by direct violence, or at a distance from the impact by transmitted force. A fracture may result from indirect violence by the sudden contraction of the body muscles in response to a sudden pull or twist. When such action results in the separation of a ligament at the point of insertion with detachment of a small shell of bone, it is called a sprain-fracture. Due to a preëxisting bone disease, as in fragilitas osseum or secondary carcinoma of bone, a pathologic fracture may occur spontaneously without apparent trauma.

Fractures have been classified according to their extent (complete and incomplete), external communication (simple and compound), number of fragments (comminuted and multiple) and direction (longitudinal, transverse, oblique and spiral). While the nomenclature is convenient for descriptive purposes, it is not indicative of the end-results, and is of no legal consequence. A good anatomic and functional result is the goal, and any deviation therefrom, be it in the nature of bad alignment or poor motion, constitutes a component factor in the ultimate disability. No arbitrary rule can be laid down as to the type of fracture producing the most discouraging results. Ordinarily, however, the incomplete, simple and oblique fracture is safer than the complete, compound or transverse. The fact that a bone is fractured does not imply permanent damage, unless there is poor union or soft tissue involvement. It is not necessary to go into the methods of treatment because they are well covered by standard textbooks. The method of reduction and fixation is of no significance provided it is handled by experienced hands. Sherman of Pittsburgh may use open reduction exclusively and get uniformly good results; Bohler of Vienna may use reduction under local anesthesia and fixation with unpadded plaster casings, and get equally excellent results; while the same methods in less skillful hands may result in infection and gangrene. A pin through the os calcis may give a perfect alignment in some hands, and an osteomyelitis in others. The fact that a bone is broken does not necessarily imply permanent disability. As a matter of fact, poor results may follow some bad fractures in spite of the best treatment, while perfectly good results follow others even in spite of the worst treatment. In the hands of an experienced man with good judgment, suitable equipment and proper technic, maximum results are obtainable even under most unfavorable conditions.

Temporary disability is the period of enforced idleness following an accident in which a bone was fractured. Total temporary disability is the condition which completely prevents a man from doing work of any kind as a result of an accident. Partial temporary disability after an accident is that part of the convalescent period when recovery progresses under active and passive treatment, and the injured person, although incapable of performing his former work, is still able to do work of a lighter nature. For example, after a fractured vertebra, a man is temporarily totally disabled when he is immobilized on a frame or in a cast; he is temporarily partially disabled when, with the aid of a brace, he can do some work but is unable to bend or lift.

Permanent disability is the residual damage or loss of use after all medical, surgical and physical measures have been employed and a sufficient interval allowed for the ordinary con-

sequences of trauma to disappear by natural means. An injury involving a fracture may be said to have recovered without permanent disability when there is: (1) firm bony union and in good position; (2) complete restriction of motion in adjacent joints and tendons; (3) return of normal bulk and power of soft tissues; (4) return of normal circulation to the parts concerned, as for example, no swelling of leg or ankle on exertion; (5) no complication.

The consequences and complications of fractures are as follows:

(1) Delayed union. Due to some constitutional debility, disease or local condition, union is delayed for an unusual length of time. However, this is a relative term, since no fixed limits can be set within which union should be firm.

(2) Fibrous union—the repair of fracture by fibrous connective tissue instead of bone. It is relatively common and usually due to interposition of soft tissue between the fragments. This condition, unless successfully operated upon, becomes a source of great disability.

(3) Non-union. It is rather rare and occurs in transverse fractures of long bones. It is frequently associated with a systemic disease, particularly syphilis. A pseudo-arthrosis or false joint may result.

(4) Vicious union—the union of 2 ends of a broken bone at a bad angle, or the cross-union of 2 adjacent bones instead of fragments (radius and ulna).

(5) Myositis ossificans—a localized ossification of muscle tissue following trauma. It may occur as a result of over-zealous treatment of a fracture, rough handling, too early movement, or too vigorous massage. As a rule, it is a self-limiting disease, and the bony mass is slowly absorbed. However, if the condition persists, operative procedure is indicated only at a very late stage, when all progressive changes have ceased. This condition is exceedingly painful and disabling.

(6) Volkman's contracture of ischemic paralysis. In this form of myositis, the paralysis is the result of muscle necrosis secondary to pressure upon the peri-arterial sympathetic nervous system. This pressure may be the result of a tight bandage or splint in the treatment of fracture, but it can also be caused by a large hematoma or other fluid under tension. As a result, the muscle cells die, fibrosis takes place, and the fibrous tissue contracts. Unless remedied early, it remains permanently as a very distressing lesion.

(7) Osteomyelitis—which has been described—prevents union.

(8) Intra-articular fractures. A very slight deformity in a joint-fracture may result in disproportionate disability, because even a slight tilt in one of the fragments may change the joint axis, with consequent deviation of the articular surface and resulting loss of function. In fractures in or about joints, reduction may often depend on the integrity of the ligaments, which may be torn and interfere with proper reduction. If ankylosis is inevitable, an attempt should be made to leave it in a position of optimum usefulness.

(9) Deformity. Some amount of deformity is apt to remain after a fracture, in spite of the most careful treatment. However, a deformity does not necessarily denote permanent disability, unless it interferes with function or distorts facial appearance. Angular deformity or gross displacement, with overriding, is likely to result in function impairment because of interference with muscular action or disturbed body statics by altering the normal lines of the axes of the joints. A mere enlargement or bony swelling does not constitute a permanent disability unless, by its situation, it causes a mechanical interference with function.

Wolff's law—"Every change in the form and function of the bones or of their function alone is followed by certain definite changes in their internal architecture, and equally definite secondary alterations of their external conformation, in accordance with mathematical laws." In accordance with this law, a bony swelling may be Nature's way of correcting a static disturbance resulting from a fracture.

(10) Shortening. This applies to the long bones of the extremities. In the upper extremity it is of no particular significance, and rarely causes disability. In the lower extremity, a slight shortening is compensated by pelvic rotation and spinal inclination, so that a good

functional result is attainable. However, a substantial shortening causes serious incapacity, limping and interference with weight-bearing. A timely orthopedic appliance may prevent secondary changes in the spine.

(11) Atrophy is the retrogressive change in a part of extremity originally well-formed and well-nourished, consisting of loss of weight, size and function. It may be the result of direct injury to the muscles and nerves in the neighborhood of the fracture, or it may be due to disuse from prolonged immobilization. Many fractures with apparently good anatomic reduction and proper retention are accompanied by atrophy and its resulting loss of power. As a rule, early active and passive motion, together with physiotherapy, judiciously applied, will help restore form and function.

(12) Ankylosis. True ankylosis really means the fixation of a joint, which rarely occurs with uncomplicated fractures. Partial ankylosis is stiffness of a joint where its movements are more or less limited. This may be due to prolonged fixation and immobilization or to associated injury to soft tissues about the joint.

(13) Injury to nerves may be caused by the same violence causing the fracture; they may be torn or lacerated by one of the broken fragments, or by being caught in or impinged upon by the callus during repair of the fracture.

(14) Blood vessels. A torn artery, with resulting hemorrhage, may be brought about in the same manner. The injury may even produce obliteration of the main arteries, to be followed by gangrene and amputation. Injury to the smaller veins may result in thrombosis, with painful swelling and considerable incapacity.

(15) Fat embolism. Globules of fat, particularly from the marrow, may be carried into the circulation after a fracture and lodge in the lungs, brain or other organs, to cause infarcts with local symptoms, depending on the extent of arrested circulation and the organ involved. This condition goes frequently unrecognized, or is of exceedingly rare occurrence.

(16) Injury to subjacent structures. A fracture, depending on its location, may cause serious damage to the underlying structures by direct or indirect transmission of the violence. A fractured skull may be followed by concussion; laceration of the brain may be caused by a depressed fragment. A fractured rib may cause pleurisy, pneumohemothorax, or lacerated kidneys; while a fractured pelvis may cause serious damage to the bladder and urethra.

(17) Tetanus, or lockjaw, may result not only from a fracture but even from a small laceration. It is more prevalent in accidents occurring in the Summer and most frequent during Fourth of July celebrations. An early injection of 1500 units of tetanus-antitoxin invariably prevents its occurrence.

X-rays. X-rays are absolutely essential from a medicolegal aspect. A poor end-result in the treatment of a fracture, without the benefit of a Roentgenogram, may subject the attending surgeon to severe criticism and even a malpractice suit. It is advisable to make a clinical diagnosis first, and use x-rays as an adjunct in confirming diagnosis. It is a good rule always to have 2 films made, exposure being in planes at right angles to each other, in order to avoid overlooking a deformity such as an angulation, or over-riding fragments lying in the same axis as the plane in which the exposure is made. A second series of x-rays gives valuable information concerning anatomic apposition and stage of repair (callus).

While radiographs are clinically valuable in all fractures, they are frequently deceptive and misleading. In the interpretation of x-ray pictures of the skull, the film may fail to disclose an existing fracture of the base, or erroneously allege a linear fracture of the vault instead of a natural bony groove. This subject gives rise to frequent disputes between experts for the opposing parties. It goes without saying that x-ray findings are not indicative of physical disability because they generally fail to show changes in the soft tissue. However, in late stages, they may disclose calcification of ligaments or ossification of soft tissues. An x-ray picture, of course, is an invaluable aid in determining whether the fracture gave rise to the bone pathology or merely served to call attention to its existence. As a rule, a fluoro-

scopic examination is unreliable in the diagnosis of fractures or bone pathology.

Maggot treatment of osteomyelitis. In spite of our progressive conquest of disease, advanced surgical technic, and improved methods of treatment, many cases of osteomyelitis remain persistently chronic, offering stubborn resistance to all forms of treatment. During the Great War, the mortality and morbidity in injured soldiers suffering from osteomyelitis was extremely high. However, a singular experience of the late Dr. W. S. Baer on the battlefield in 1917 was indirectly responsible for inauguration of the treatment of osteomyelitis with live maggots. After a certain battle, 2 soldiers with compound fractures of the femur, with large flesh wounds, had been left on the ground for 7 days without shelter, food, water or medical attention. Although weak from thirst and starvation, their condition was good and they showed no signs of fever or general infection. On removing the clothing from the wounded part, it was found to be filled with thousands of maggots, and underneath, instead of pus, healthy pink granulation tissue. Those battlefield observations made such an impression on Dr. Baer that, upon his return to civil practice, he put them to practical use with eminently satisfactory results.

At the Annual Meeting of the American Orthopedic Association in Chatham, Mass., June 21, 1931, Dr. Baer related his experiences with the wounded abroad and with 89 cases of osteomyelitis in Baltimore, illustrated with Roentgenograms, corroborated with photographs, compared with the older methods of treatment, and came to the following conclusions:

(1) Maggots have been found to be a tremendously useful adjunct to thorough surgical treatment of chronic osteomyelitis, and, in our opinion, are far more successful in securing permanent healing of these extensive wounds than any other method tried by us.

(2) Maggots, by their digestive action, clear away the minute fragments of bone and tissue sloughs caused by operative trauma in a way not accomplished by any other means. This is a tremendously valuable asset in the healing of a wound.

(3) Maggots cause wounds to become alkaline and in this way diminish growth of pathogenic bacteria.

(4) Maggots seem to have other more biochemical effects within the wound itself, and perhaps cause also a constitutional reaction inimical to bacterial growth.

(5) Maggots, raised and sterilized in the proper manner, may be used in any wound without risk to the patient.

(6) The post-traumatic or postoperative general condition of the patient is better in maggot treatment than in the older forms of treatment where infection was combated by chemicals or other types of dressing. There is less absorption and less toxic reaction.

A similar observation was made by Dr. Crile, who stated: "In the wounded who lie out in 'No Man's Land' for 2, 5 or 10 days, it has been found that the wounds that have done best are those that contain maggots."

Malingering. Malingering, or the feigning of disability from injury to bone, is not infrequent. It is more apt to occur in time of economic stress and strain, depression and universal unemployment. This is particularly true of some men who had been injured previously and received no compensation for same, or those who sustained a minor injury and had been subsequently laid off by reason of lack of employment. A fixed idea takes possession of the injured workman that he is being wronged, and that an accident, no matter what its nature, constitutes a compensable condition. It soon becomes an obsession; he even accuses his own legal and medical adviser of conspiracy to defraud him.

It is scarcely possible to feign a fracture, since an x-ray examination would soon reveal the truth. However, the malingerer may complain of pain and tenderness, and claim weakness, lameness, stiffness and swelling on exertion. Fortunately, his complaints seldom follow anatomic lines or physiologic processes. In the absence of visible evidence of trauma, a marked discrepancy between the symptoms complained of and the anatomic and physical findings should immediately put the alert examiner on his guard. He should observe the general mental attitude of the patient and, by diverting his attention, press the alleged point

of tenderness or move an allegedly stiff limb or painful joint. A surprise visit might disclose a fictitious limp and stiffness while observation of pulse and pupil may reveal simulated pain.

SURGERY OF THE VEGETATIVE NERVOUS SYSTEM

Alexander Strelinger, M.D.,
Elizabeth, N. J.

Unicellular beings use their whole protoplasm for every necessary activity. Multicellular beings on a certain scale of development differentiate their cell-groups to suit certain purposes. The mass of tissue in human being differentiated to the purpose of conducting nervous stimuli is the nervous system. This system is subdivided into the voluntary and involuntary nervous systems. We shall use the term "vegetative nervous system" for identifying the latter.

The question comes up, how can we determine whether any nervous center or nerve fiber belongs to the voluntary or to the vegetative nervous system? Muller gives the definition that nerves conveying impulses from or pertaining to the outside world belong to the voluntary system; nerves pertaining to vital functions revolving inside our bodies are the vegetative nerves. He uses the terms "outside-world nervous system" and "life nervous system". American literature reproduces these terms with the words "extero-fective" and "entero-fective" nervous systems. This does not solve our classification problem. Therefore, it will be worthwhile to gather some other identification data.

We were taught that the cerebrum, cerebellum, medulla oblongata and medulla spinalis, including the nerves arising from them, make up the voluntary nervous system, leaving the rest of our nervous apparatus to the vegetative. The classification is not perfectly correct; we know that the cranial vagus and the sacral vagus arise from parts mentioned above, and that a number of the nerve centers, especially those in the hypothalamus and tuber cinereum, and the so-called antero-lateral horn cell group in the spinal cord, with pathways arising from these, are definitely of sympathetic nature. Therefore, the gross anatomic division of our nervous system into 2 systems is futile. But until now the histologic classification failed also. We can seldom determine just by looking at the microscopic picture whether a neuron or any part of it belongs to the voluntary or vegetative nervous system. There are microscopic differences; the Nissl-structure, especially, often gives us valuable information, but seldom definite.

The descending degeneration after severing a nerve from its central cell group often gives definite information in identifying pathways of the voluntary nervous system; but, due to the different structure of the vegetative nervous system, it gives less information in the latter system. Our muscles with voluntary nerve supply undergo degeneration after the nerves leading to them are severed, and this degeneration soon produces changes in their electric excitability. Applying a weak galvanic current, the muscles will not contract under normal conditions. Increasing gradually the intensity of the current, we find that interruption of the current will produce contraction before the connection of the current has any effect. We also find that, with applying one small and one large electrode, this interruption will produce contraction when the small electrode is the negative pole in our current, but not when it is the positive pole. In degeneration of the muscle, the intensity of current has to be larger to produce contraction, and the first contraction appears when the small electrode represents the positive pole.

We do not find this reaction in organs with vegetative innervation. If, for instance, we sever all nerve fibers supplying a section of the intestine, the smooth musculature of the intestine will carry on its movements in spite of the severed nerves. It will not degenerate. The explanation of this phenomenon is that the intestine, and also other organs with vegetative innervation, have extensive nerve webs in their walls. In the intestine these are the Meissner and the Auerbach plexi. These webs are responsible for the automatism of the vegetative organs. Removal of the webs will be

followed by degeneration, as severing the nerves of voluntary muscles was followed by degeneration. This explains why operative intervention seldom leads to serious effects in organs with vegetative innervation. They have the tendency to continue their function and establish a functional balance, if only their nervous webs are left intact.

Furthermore, we find differences in the 2 nervous systems in the speed of transmission of nerve stimulus. The nerve impulse travels in voluntary nerves with an approximate speed of 60 m. per second. This figure is not invariable. It may change in the same nerve due to changed conditions. For instance, disease or exhaustion will decrease the speed of the nerve impulse. But in vegetative nerves this speed is considerably less—about 4 m. per second. This is not a standard figure either. In the vagus nerves, the speed of the impulse is about the same as in voluntary nerves. Some physiologists classify the vagus nerves, for this reason, in the voluntary system.

We can mention the chronaxy also. This is calculated from the intensity of an electric current used to stimulate the nerve and the length of time elapsing between stimulation and muscular contraction. This chronaxy for voluntary nerves is about 0.3; for vegetative nerves, from 4.7 to 24. The chronaxy of the heart muscle and its nerves is between the figures for voluntary and vegetative systems, in accordance with other features placing the heart and its nerves between the 2 systems.

Vegetative organs have a double innervation, resulting in antagonistic effects. As a rule, we find that stimulation of the sympathetics has an effect contrary to that produced by stimulation of the parasympathetics. The action of the heart quickens on sympathetic stimulation and slows on vagus stimulation. Peristalsis of the bowel will be stronger on vagus stimulation and inhibited by sympathetic stimulation. In this respect Langley's experiment is interesting. When the cervical sympathetic trunk is severed, stimulation of the cranial stump, having apparently no connection with the heart, still results in tachycardia, because the central stimulation of the sympathetic causes also a central inhibition of the vagus. This antagonistic innervation is characteristic for vegetative organs. The components of the antagonistic innervation effect a certain tonus. If one component of the innervation is excluded, the other usually produces definite changes in the movements of the end-organ, but the changes are usually transient. When all nerve fibers leading to a vegetative organ are severed, but the webs in the wall of the organ are left, it will function automatically, without much change.

The action of the vegetative nervous system is mostly stimulation of smooth muscle, and the centripetal transmission of sensory impulses from vegetative organs, including blood vessels.

While the pathways of the voluntary nervous system are usually consolidated in nerve trunks, and can be easily identified, the vegetative pathways might run in nerve trunks and might run in thin strands following the blood vessels. Their identification is often difficult. Variation from person to person is common and often considerable. Clinical experiences demonstrate this well. In case of malignant tumor in a lower extremity, sectioning of the cord, causing complete sensory and motor paralysis, which means exclusion of the voluntary nerves of that extremity, usually also gives relief for the pain caused by the tumor. But there have been cases recorded in which such a cordotomy did not give relief for pain, and a second cordotomy at higher level had to be done. The explanation of this is that the pathways of pain must have varied from normal and entered the cord at higher level than the voluntary nerves.

Kappis accounts for failure of splanchnic anesthesia in certain cases of upper abdominal surgery by the fact that, normally, all sensory pathways of the stomach go to the semilunar ganglions, but in variations, some fibers run to the lumbar region and enter the cord here. On the contrary, spinal anesthesia might be ineffective if sensory pathways run high up alongside the aorta before they enter the cord, and the level of entrance is not affected by the anesthetic administered at a lower level. As further example of possible variation of sympathetic pathways, we can quote that anginal pains usually can be relieved by injection of the D I-D IV roots paravertebrally. Some pa-

tients unrelieved by this injection showed improvement after injecting C VI-C VII. Kappis and Laeven use, as a rule, injection of the lower cervicals, whereas Mandl uses injection of upper thoracics.

The pathology of the vegetative nerves and nerve centers is not well known. Different changes, especially degenerative changes, have been described, but these do not occur regularly and their form of intensity may vary in clinically identical conditions. Therefore, resected vegetative nerve parts, examined microscopically, will not reveal the clinical nature of the disease, even with changes present and clinically good results of the resection.

Summarizing these facts, we expect that surgery on vegetative nerves will be indicated in diseases of the organs with vegetative innervation, this having 2 antagonistic components; and differences in results of operations performed on cases of identical pathology can be explained by wide variations inherent to the vegetative system.

Let us see the clinical application of surgery of the vegetative nervous system. I shall try to group the different operations according to indications, lacking a better basis.

Attempts have been made to influence blood pressure. Craig and Brown report that partial resection of the lumbar chain, unilateral adrenalectomy, and denervation of the adrenal gland on the contrary side, did not show any persisting vasomotor response in animal experiments.

Campbell reports a case of retinitis pigmentosa treated by superior cervical sympathectomy. He also quotes the report of Royle comprising 5 cases. Results were not decisive.

Certain cases of pain in the head showed results following operations on the superior cervical sympathetics. Davis and Pollock showed experimentally that stimulation of the superior cervical ganglion produces pain referred to the region of the fifth nerve.

Bruenning had favorable experience with denervation of the kidney pedicle in so-called nephritis dolorosa, and also in beginning hydronephrosis.

Danielopolu claims that there are 3 factors in the genesis of epilepsy; a blood, a cerebrospinal, and a vegetative, factor. These are arranged in a vicious circle. Operative attempts were made to stop the attacks by the so-called sinocarotic neurectomy, plus removal of the carotid node. Clinical results were not satisfactory, and Danielopolu concludes that cardio-aortic fibers ought also be removed. McKenzie reports a case of epilepsy treated by resection of the right splanchnic nerve, right sympathetic chain, and ramisection at the origin of the great splanchnic nerve, with some improvement.

Bronchial asthma is also one of the possible indications for surgery on the sympathetics, but Bruenning deprecates surgical proceedings in asthma cases.

Bircher reported certain cases with disturbance in the chemistry and mechanics of the stomach, favorably influenced by sectioning the vagus, sometimes combined with sectioning the sympathetics. Berg sections the vagus routinely in addition to stomach resections performed for gastric ulcer.

Chronic deforming arthritis, especially forms causing clinical and pathologic findings at the distal ends of the extremities, have responded well to sympathetic surgical procedures. Two types of operation are recommended; peri-arterial sympathectomy and chain resection. Many clinicians have the opinion, based on experience, that increase in the blood flow of the extremities will invariably be followed by improvement. We have an approximate way to determine, preoperatively, the probable amount of improvement, by novocaine injection and notation of the increase of temperature of the diseased parts. Raynaud's disease, intermittent claudication, and Buerger's disease, can be treated by similar measures. Braeuker recommends sectioning the communicating rami and peri-arterial sympathectomy. He found, in cases of Raynaud's disease, pathologic changes in the high sympathetic centers as well as in the most peripheral peri-arterial plexuses, and naturally these are not amenable to surgical measures. Sperling, Jelsma and Rogers report 3 cases of Raynaud's disease treated by multiple operations, with improvement. Ito and Asami consider lumbosacral sympathetic ganglionectomy of great value in intermittent claudication, and believe that it is also of benefit to patients with Buer-

ger's disease who do not show too far advanced arterial changes.

The surgical treatment of Hirschsprung's disease was much advanced by the work of Learmonth and Rankin. It is necessary to review briefly the innervation of the descending colon, sigmoid and rectum from the operative point of view. The nerve supply of the sphincter comes, in the greatest part, from the lumbar section of the sympathetic chain. This section gives off fibers first to the presacral nerve of Latarjet, called also the superior hypogastric plexus of Hovelacque, which in turn supplies the rectum. This presacral nerve is situated on the anterior surface of the sacrum, just beneath the peritoneum, below the bifurcation of the aorta. But the descending colon and the sigmoid derive most of their inhibitive innervation from the so-called inferior mesenteric nerve. This nerve originates from the aortic plexus, a short distance below the beginning of the inferior mesenteric artery, and, following mostly the vessel distribution, supplies the descending colon and the sigmoid. Sectioning of the inferior mesentric nerve produces paralysis in the inhibitory innervation of the previously mentioned intestinal segments, and is one of the beneficial factors in Hirschsprung's disease. It seems to be of greater importance to paralyze the tonic contraction of the rectal sphincter. This can be achieved by sectioning either the lumbar chain or presacral nerve. These 2 structures do not carry quite identical nerve fibers, but clinically the sectioning of either seemed to be effective, especially in pathologically increased sphincter tonus. Rankin and Learmonth sectioned the presacral nerve also in an endeavor to improve cases of chronic constipation without demonstrable pathology, especially where the barium meal reached the descending colon in normal time, but failed to empty. The clinical results were not satisfactory. The explanation offered is that, although in Hirschsprung's disease there is invariably a hypertrophic musculature of the descending and sigmoid colon, the chronic constipation cases show either no change or atrophy in the musculature. The clinical results obtained by Learmonth and Rankin in Hirschsprung's disease are good.

Learmonth also did considerable work on certain bladder conditions. He claims that sympathetic neurectomy is indicated in cases of vesical paralysis in which the lesion is situated in the parasympathetic pathway and the sympathetic pathway is intact. The patient must be continent and renal condition satisfactory. Sympathetic neurectomy alone, or combined with local procedure, has proved effective in dealing with spasmodic conditions of the neck of the bladder. It will relieve pain due to spastic conditions. It was tested in interstitial cystitis, inoperable cancer of the bladder, chronic cystitis of unknown origin, and also in persistent irritability of the bladder after removal of one tubercular kidney. The type of operation might be again lumbar chain resection or resection of the presacral nerve.

The same types of operation have been practiced in female pelvic conditions. The main indications are (after Fontaine and Herman): (1) No pelvic pathology but persistent pain warranting major operation; (2) minimal pathology not warranting other intervention (sclerocystic ovaries); (3) lesion cannot be removed, neoplasms. These authors include in the possible operations, sectioning of the ovarian nerves coming from the nerve plexus surrounding the ovarian vessel, situated in the ovarian ligament; and also peri-arterial sympathectomy of the iliac vessels. Cotte reported 7- and 8-year results on 22 cases without pelvic pathology, and 14 cases with pelvic pathology, treated by resection of the presacral nerve; his results are encouraging. Relief of pain in different pelvic conditions in the female is one of the most promising fields of sympathetic surgery.

Angina pectoris without demonstrable heart pathology constitutes an important indication for sympathetic surgery. The majority of the nerves supplying the heart run by way of the cervical vagus and cervical sympathetic nerve. But according to Kondratjev, there is a collateral trunk parallel to the ganglionated cord in the dorsal region, which communicates in one direction with the ganglionated cord itself, and in another direction with the plexus in the posterior mediastinum. This latter plexus is in direct connection with the aortic plexus. Therefore, complete bilateral resections of the

cervical sympathetics and the vagi still leave pathways which may conduct pain, and this fact is observed sometimes after the abovementioned extensive resections. On the other hand, we must remember that bilateral operations on the cervical sympathetics showed high mortality in the presence of demonstrable heart pathology. Therefore, we see a tendency to exclude patients from operation who exhibit definite pathology of the heart, and to consider only such patients operative as have definite pain, with left shoulder and arm radiation, without changes in the heart muscle demonstrable by electrocardiogram. Hyman and Parsonnet differentiate sharply between angina pectoris cases without pathology and cases with demonstrable heart pathology. The types of operation on the cervical vegetative nerves for angina pectoris are numerous. Complete resection of the cervical sympathetic chain, including the cervical superior and the stellate ganglion, showed a high mortality and was not followed by the expected results; but resections of the chain and stellate ganglion without disturbing the superior ganglion showed better results and less mortality. It was observed that operations on the cervical section alone are not satisfactory in every case. This observation led to the attack on lower segments in 2 forms: (1) the operation of Gaza, who resects the stellate ganglion and a section of the dorsal sympathetic by posterior route, and (2) the paravertebral injection of the first 4 dorsal segments. Whereas Gaza's operation showed results in some cases, it is a serious procedure. The paravertebral injection, as practiced by Mandl, is not serious and has more or less lasting effects in nearly every case. It can be easily repeated and is of considerable therapeutic help in angina. Mandl uses novocaine and tutocaine for his injections, with effects lasting sometimes 6 months. Other authors report the use of alcohol in order to obtain more lasting effects, but alcohol showed extensive and strong irritation in many cases.

I have attempted to show that the surgery of the vegetative nervous system is complicated and presents many angles. The reasons that our clinical results are not satisfactory in many of the problems mentioned, and that these results are not uniformly accepted by all investigators, are partly the complexity of this field of surgery but mainly the insufficient knowledge of the anatomy and functions of the vegetative nervous system at the present time.

PERFORATED GASTRIC ULCER

Joseph A. Visconti, M.D., L.L.B.,
Hoboken, N. J.

Case history. R. M., aged 20 years, had "stomach trouble" for 1 year, which was evidenced, among other things, by epigastric pain occurring usually 1 hour after meals, and which was relieved by sodium bicarbonate. At 3 p. m., December 18, 1932, he was seized with an unheralded epigastric pain, attended with nausea and followed by vomiting. The pain then became localized in the right lower quadrant, associated with tenderness in this area. On admission to St. Mary's Hospital, temperature was 96°, pulse 80, blood count: white blood corpuscles 28,800; polys, 88%; lymphs., 11%; mono and trans. 1%. Urinalysis was negative.

Physical examination revealed tenderness and muscle spasm in right lower quadrant, over McBurney's point. However, there was also some tenderness in the epigastrium, but no boardlike rigidity which unmistakably points to perforated gastric or duodenal ulcer.

At 8 p. m., 5 hours after onset, operation was performed. The low gallbladder and high appendix incision, so termed by Dr. John Erdman, was made. The appendix was found to be acutely inflamed; so much so as to warrant a speedy closure consistent with such positive findings, explaining a definite symptomatology. But this epigastric pain and ulcer history of the past—did not the great Dr. Moynihan say that most gastric ulcers are found in the right lower quadrant? If that was true, then this case ought to be concluded. The patient would have lived or died, and the condition have been labeled as acute appendicitis with peritonitis; the story of countless cases, attested to by many surgeons. But such was not the sequence. The upper end of the wound was enlarged, and the more the enlargement, the

thicker was the peritoneum above contrasted to that below. On sight, in the abdominal cavity, was seen a trickle of white exudate, having its source from above. Further inspection presented in full view a pencil-point infected perforated ulcer. Nowhere were any stomach contents to be seen. A simple closure was effected, and an uneventful recovery was made. Thus was explained more satisfactorily the epigastric pain and ulcer history.

It can be said then, that most gastric ulcers are found in the right lower quadrant; some acute appendices are found in the upper right quadrant.

Perhaps this will serve to recall the fact that many cases listed as "tough luck", following appendectomy, where the diagnosis even at operation was certainly believed to be appendicitis, may have been like the one reported here. I have been told of a case so proved at the autopsy table.

I am mindful that, in the face of acute symptom-sign explainable pathology, romancing about the abdomen is indicative of poor judgment, but this is not so where there is a reasonable probability that the full story would not be told unless an extra search was undertaken.

Medical Ethics

John Hammond Bradshaw, M.D.,
Orange, N. J.

"Not the wrongs done us harm us, only those we do to others."—Longfellow.

This little sentence from one of the pages of Longfellow's diary becomes more interesting the more one reflects upon its wisdom. The sweetness of the poet's nature was known, not only to his intimates, but was acknowledged by the world. And the world, although less than 8000 miles in diameter, is really a very big place. It is so easy to harbor a grouch. It is so easy to think someone, even perhaps a friend, has done us an injury, has damaged our mental, spiritual, or our material welfare; so we think it only righteous for us to be hurt and to feel aggrieved.

But reflect, if only for a moment, upon the second half of the poet's little sentence. How about the wrongs we do to others? Naturally we exclaim: "We never do them any wrong." What a perfect, what an immaculate person that man is who can say this in very truth! Do we not know that often we are so engrossed in our own affairs we fail to remember the rights of many other people? Now we have every reason to think our own welfare, our own business and our own happiness should come first. If we did not do this would we not be pushed to the wall? We have had some rather trying experiences in our past life that lead us to this very belief. Let us, however, try to remember which one of the parties involved came out best *in the long run.* If one does a man a wrong, intentionally or otherwise, some day that wrong will, like Banquo's ghost, unexpectedly appear; if not to the eye of the body, then surely to the eye of the spirit. Tell me, now, which does a man the more telling and the more permanent injury? The body will pass away; the spirit is eternal.

Esthetics

WHAT DOES MUSIC MEAN TO THE LISTENER?

(In the New York Times Book Review of Sunday, August 6, you may find an interesting report by Richard Aldrich upon a new book entitled "Music and Its Lovers", written by Vernon Lee, Litt. D., and dealing with the question presented above; i. e., "precisely what does music mean to listeners". As we have occasionally used *music* as a theme for our Department of Esthetics, this unusual study seemed an opportune presentation; and we use it here with due credit to the author of the book, author of the review—both named above—and the publishers, E. P. Dutton and Company and the N. Y. Times.—Ed.)

There have been not a few attempts to analyze the effects of music on various personalities. There has perhaps been the idea that music of various kinds, in various ways, has definite effects, but attempts to deduce any laws or general principles governing such effects have not resulted in anything definite or determined. The explorers in this field have come out of that same door through which they entered. It need not be assumed from this that they have brought nothing of value with them. This book of Vernon Lee's is enough to refute that assertion. But whatever else it is, it is not a definite esthetic doctrine.

There have been few attempts so far-reaching as this one. The distinguished writer

who signs herself Vernon Lee disavows explicitly any deep or wide technical knowledge of music; but an intelligence and a literary power such as hers have inevitably much of value and interest to contribute to such an investigation as she has undertaken. She has been writing for many years about many things of the spirit, including music; but she cheerfully characterizes one of her earlier books, in which music is touched on, as "very crude", and another as answering a musical question "entirely wrong". This book is based on an elaborate series of questionnaires, sent out to the greatest variety of people, in English, French and German—not ordinary questionnaires, not infringing in the least on the ground of The Literary Digest, but inviting much self-analysis and thought by people who can think; and providing an opportunity for discussion on the part of the questioned. The English version of the questionnaire is given at the end of the book. The answers provide the author also the opportunity for acute discussion and analysis.

That the people who were invited to answer Vernon Lee's queries were altogether of the intelligentsia may be taken as a matter of course; but they were of the greatest variety of views, training and competence in musical matters. There were a few professional musicians, many amateurs more or less advanced in knowledge and technical acquirement, many whose knowledge of music went no further than the power of intelligent listening and of analyzing their own responses to music, often acutely and subtly, and from a psychologic point of view. And, finally, there were those who frankly acknowledged themselves unmusical.

The manifold result of all these responses gives Vernon Lee the occasion for elaborate and prolonged discussion of all that is involved, and from many different points of view. The people questioned are asked as to their capacity in playing or singing, reading and writing music, improvising, their musical memory, their power to distinguish harmonies and the qualities that harmony has for them; whether music without words or suggestive titles expresses human emotion, either of the composer or of the listener; whether such music "puts you into moods different from the one you happen to be in"; or intensifies already existing moods; or whether you recognize, without participating, that music "represents" varieties of human emotion and mood and whether any reasons can be given to account for different responses; whether music produces an emotion *sui generis;* whether it seems to have a meaning, a message, beyond itself or remains "just music", with no suggestion or meaning beyond itself; a statement is asked for of preferences in regard to Bach, Mozart, Beethoven (earlier or later), Chopin, Wagner; and whether Wagner seems to stand apart and to produce emotional effects different from those of other musicians; whether they think music can have a good or bad effect on character or actions; whether it is "yon side of good and evil", and the understanding of these questions with regard particularly to Wagner; whether hearing music disturbs or facilitates trains of thought or work, and whether it is preferred to listen to music or overhear it while otherwise employed; whether, hearing music, you think of other things or whether it excludes all other thoughts, or whether your enjoyment is partly of suggested images, memories and stories.

Have you days of non-receptivity? When there are words do they seem of importance or disturb the music, or are they a negligible item? Is opera a higher or lower form of art than symphony or chamber music? Are you haunted by music? Do the events of your life translate themselves into music, either your own or remembered? Is your enjoyment of music calm, lucid, serene or bracing; or excited, overwhelming, spiced with pain, exhausting; in Nietzsche's words, Apolline or Dionysiac?

These questions cover, it will be thought, almost the whole gamut of human relations to music. The answers give, it may also be supposed, a suggestion of most of the responses that may be aroused in the listener, from the accomplished musician to the tyro.

Vernon Lee plunges into this great sea of response with unrestrained joy and stirs up the waves of discussion with intense ardor. It is not a combat in which she is engaged. She has opinions of her own, which appear from time to time; but she is little concerned with validating them. Her concern is rather to give the fullest understanding of her correspondents' ideas and reports. They are many and varied: "Many men of many minds." The book is an insidious temptation to quotation; but in its great extent and complexity quotation could give but little access to its wide range.

The matter of the "meaning of music" is one that naturally enters into this inquiry. The

author takes Beethoven's trio, Op. 97, as one of her starting points. Of the 4 movements her correspondents give 45 "meanings". They range all the way from "nothing" to most elaborate analyses. Thus, of the first movement: "vague longing for isolation in a sunny field"; "a procession stately and slow"; "something noble and calm, a great achievement"; "energy launching out, wind in the sails, jolly bear dancing"; "Sehnsucht à la Mozart"; "joyousness, poplars, dawning human doubts, crocuses, green, green, green." There is even greater variety suggested by the other three movements, including answers from two insensitive listeners who say "nothing" and another "sounds which say nothing to me".

One of the author's conclusions is that her experiments seem to prove that music has such power of expression as is frequently claimed for it, and that music can and often does convey a "meaning", a message beyond itself. Some might object that conveying so many diverse messages, it finally conveys none. Important is her further conclusion that her results "show even more clearly and undeniably the nature (the 'what it is about') of the 'meaning,'; the contents of the 'message' even when coinciding with the ascertained one (as by words or title) is added by the 'hearer' or the 'listener' ".

Music Should Be a Basic Study in Our Education

(From N. Y. Times, Aug. 13, 1933.)

Music, which is widely mentioned as one of the "fads and frills" of schools by the campaigners for economies, has passed out of the "fad" stage and has become a "basic subject", according to a monograph on "Instruction in Music and Art" just issued by the Federal Office of Education.

"More than 26% of the students in high school take one or more forms of music instruction", the office reports. This is said to represent a greater percentage than that which takes many of the traditional subjects such as geometry, physics, Latin, French, German and others.

The monograph is based on studies made for the National Survey of Secondary Education, conducted by the office. Art appears to have made less progress than music, and education work in this field is held to need considerable improvement.

Woman's Auxiliary

(In "California and Western Medicine", the Journal of the State Medical Societies of California, Nevada and Utah, Vol. 33, p. 686, Sept. 1930, we noticed an editorial concerning the Woman's Auxiliary which, though published so long ago, might well have been prepared for our own Auxiliary, and which remains *à propos* today.

In consequence we are reproducing a portion of the editorial, and in addition to recommending its perusal, wish only to remind you that we have our own State Society Auxiliary Blue Book, which was prepared by the Editor several years ago, and which was then distributed to all our Auxiliary members through the County Society Auxiliaries and, upon request, to many other State Society Auxiliaries throughout the nation. We believe there are still some copies available, if desired, for use in the counties of New Jersey.—Ed.)

Woman's Auxiliary to the California Medical Association

County Medical Societies are again urged to form Woman's Auxiliaries.—The officers of all the component County Medical Societies of the California Medical Association, in which no auxiliaries as yet have been organized, are again urged to give this matter their consideration and support. The auxiliary leaflet (we have our own; the first to have been published) which has been published gives full instructions as to best methods of procedure. It is suggested to all who are interested in prospective organization that the central office of the Association be written to with a request for such number of copies of the leaflet as may be desired. By following this method, the formation of a County Auxiliary becomes a comparatively simple matter.

The California County Auxiliaries which have been formed to date, already have given much pleasure to their members. As time goes on, these Auxilaries may be counted upon to give expressions of increasing service, not only to members, but to the interests of the medical profession and also to the public health and to the general welfare of the communities in which they are established.

As to the future of the different Auxilaries, that naturally will depend in good part upon the membership and upon the officers and committees who are chosen to taken the leadership in the various phases of auxiliary work.

Some suggestions on fundamental procedures. If we were at this time to stress some of the important matters which each Auxiliary should observe, our tabulation would include items such as the following:

(1) The fundamental rules of government of procedure for each Auxiliary should and must be those authorized by the State Medical Society. Any additional rules which might be adopted by an Auxiliary must not be in conflict with rules which were approved by the State Medical Society.

(2) The officers and members of each County Woman's Auxiliary should keep constantly in mind that by the basic rules, the contact committee representing the local County Medical Society is stipulated to be the President, the Vice-President

and Secretary of each such County Medical Society. The executive officers of each county auxiliary should maintain proper contacts with this advisory committee which has been provided to represent each County Medical Society. All matters of policy, when of possible delicate or intricate nature, should be presented to the medical advisory committee for opinion. This provision contemplates an arrangement whereby a County Auxiliary shall carry on most of its county work, as a county rather than as a State function, and in full coöperation with County Medical Society officers.

(3) Special care should be constantly taken that no officers or members of an Auxiliary speak in the name of the local County Medical Society or of organized medicine, except as express permission may be granted in specific instances by the Medical Advisory Committee.

(4) The social meetings would naturally be in line with the inclination of local members. Non-expensive types of entertainment, safeguard against many dangers to the treasury and to other organization interests.

(5) Auxiliary members who also hold membership in different Woman's Clubs and organizations, can render the very best of service by taking a real and active interest in all activities of such various Woman's Clubs and organizations which trench on the domain of public health. In short, members of Auxiliaries should occupy positions of leadership in all public health activities of such extra-auxiliary woman's organizations. Few types of service can be made to be of more value than this.

(6) The public health program or studies to be carried on by each Auxiliary should reflect matters existing in local environments. There are a host of such problems, all of which can be studied and reported upon by a Public Health Committee and its special sub-groups or sub-committees. Among such might be mentioned: water supplies; food supplies; housing conditions; school health problems (construction of school buildings, care of under-nourished children, supervision of wayward or deficient school children); tuberculosis problems; acute epidemic problems (such as infantile paralysis); city and county health departments; county hospital problems; miscellaneous clinic and health center problems; and so on.

Such a public health committee could consist of 5-10 members, each of whom in turn was chairman of one or more special sub-committees of 3-5 other members of the Auxiliary, to investigate one or more of such problems as are above enumerated.

(7) Philanthropic activities, special study courses and similar activities are other matters worthy of consideration, but in these as in all things of growth, no set method of procedure can be laid down for all alike. The task before each Auxiliary is to discern what are its local problems and then to make an effort at proper solution and betterment.

(8) And finally, as regards so-called civic politics, whether of City, County or State nature, the less direct activity in such, probably the better in the long run. Here again the best course to follow can be made more easy and clear, by utilizing the services of the Medical Advisory Committee or its designated representatives. In all this, the major thought should be on principles and service, rather than of spectacular publicity or personalities.

Woman's Auxiliaries Can Render Big Service. In conclusion, it is well to keep in mind that a Woman's Auxiliary is not intended to revolutionize all future activities having to do with medical or public health problems. The Auxiliaries are primarily intended to provide a means of fellowship and coöperative endeavor for the women members of physicians' families. In union there is strength. Busy physicians can give but little time from their regular work for these accessory public health and medical problems. A Woman's Auxiliary can bring to the aid of organized medicine a valuable group of intelligent women, who, through their auxiliary organization, will be in position to render splendid service to its respective community in public health, general welfare and medical problems. That being the case, it would seem that auxiliaries can and will more than justify their right to existence. And as for California, the editor believes, as time goes on, that such will be the final judgment of the medical profession of this new supporting arm to the public health, medical and public welfare interests of California and its constituent counties.

WHAT OUR MEDICAL AUXILIARY SHOULD MEAN TO US

Mrs. J. C. Bennett, of Jefferson

(From the Journal of the Georgia State Medical Society of May 1931.)

In the first place, it would be well to ask ourselves why we are members of the Medical Auxiliary. We should belong to the Auxiliary because—

We believe that our husbands' profession is one of the finest in the world; almost the greatest work a man can do. We should wish to back them in their work, to which they give their lives.

Even if we belong to many other organizations, I believe that first we should center our interests and energies on the work which is nearest our homes and our hearts, because our positions as doctors' wives surround us with opportunities for investigation of the health question, and an understanding of that problem which perhaps others may not have.

Through the Auxiliary we may become the friend of any other doctor's wife, not only of our State but of the United States, and thus enrich our own lives. We should be members of the Auxiliary because we accept the following statement that, "Each succeeding generation of the race is the beneficiary of the care bestowed by the womanhood of the generation before it". And we should wish to carry on. The principal function of our Auxiliary should mean to us education of the public in health matters. But doctors' wives cannot educate others until they have become educated themselves. The first work, therefore, for the members of a State or County Auxiliary should be *self-education* through reading and study programs.

One of the best fields for educational work for health open to our Auxiliary lies in women's clubs.

Doctors' wives who have made themselves intelligent about public health principles, and informed about scientific methods of disease prevention, are always being sought for chairmanships and public health committees in parent-teacher associations and in women's clubs. These positions

offer opportunities for health education which should be welcomed by Auxiliary members. We often wonder in our County Auxiliary what we can do without the finances needed.

A County Auxiliary could put on study programs covering the fundamentals of personal and public hygiene. Study our local health conditions. Study our own county official and non-official machinery for disease prevention and health promotion.

Where we have no full-time county health department, ask the State Health Department to tell us what the county needed and what we could do to improve conditions, and then follow their directions.

The rural health problem could be solved better with a County Health Nurse.

Then it is necessary to push the extension of Hygeia with other matters of health education, especially in every rural school and district.

The study of health should be a part of every school curriculum and, also an annual physical examination for every child, not just those in the larger cities.

Annual physical examinations for adults as well as children should be urged; and it would be well for the Auxiliary members to set the examples by starting on themselves first.

Texas, the mother of our Medical Auxiliary, has added the birthday feature to the physical examination program. Have the Secretary to enroll the birthday of each member, then the week of the birthday, set a definite time for the examination, which is so easily postponed when one is apparently well. The Secretary sends a birthday card as a reminder of the occasion.

The President of a Texas Auxiliary related her experience in connection with her thorough examination. Her birthday was in September and the first meeting of her local Auxiliary was early in October. Naturally she said she wanted to help raise the number of examinations to be reported at that meeting, so she went down expecting to be told that she was a perfect specimen of healthy womanhood; said she couldn't have felt better. Imagine her surprise when a lump in the breast was found. A decision to operate at once met with enthusiastic readiness on her part. The tissue examination determined that it was not a malignancy, but she said one could readily understand her gratitude to the physical examination.

As members of the Auxiliary our task is indeed one of tremendous magnitude, requiring much labor and self-sacrifice. But a large health foundation may grow out of the seeds we are sowing.

By joining hands in this lofty enterprise we can help build a paved highway to health and happiness. With the physicians as our teachers; their wives the messengers; our press the promoter; our clubs the salesmen; and our influential men and women the capitalists.

We may be charged with being dreamers, but history proves that "the onward march of science, religion and civilization has been led by dreamers". After all, the real quest in life is service.

Service is the keynote of our work, and is perhaps the greatest thing in human life.

To serve, and to be of service—what other opportunity affords so great a degree of personal satisfaction?

Therefore, our Auxiliary should mean to us—*service of love.*

County Society Reports

BURLINGTON COUNTY

Joseph M. Kuder, M.D., Reporter

The regular September meeting of the Burlington County Medical Society was held at the Burlington County Hospital, Mt. Holly, on September 13, and was called to order by its President, Dr. John S. Conroy, at 1.30 p. m. After introducing about 12 visitors whom the society was pleased to welcome to its deliberations, the Secretary read the minutes of the preceding meeting, which were approved as read.

Dr. Ephraim Mulford, Chairman of our County Committee on the Costs of Medical Care, reported that his committee had a report ready for consideration, and that it would be presented in its final aspects at the next regular meeting of the Society. Dr. Mulford stated that in Burlington County the work relating to his committee is being well taken care of, and that many features pertaining to such work on a national scope do not apply to problems existing in a county such as ours. The Majority Report of the National Committee, evolved during Ex-President Hoover's administration, relative to group formation among physicians, was deemed inapplicable to rurual communities and to problems such as exist in our own county. Therefore, Dr. Mulford's committee does not recommend the National Committee Majority report for adoption in Burlington County.

Dr. Mulford, reporting on the work of the committee relative to specialization, stated that the matter was laid over, for the time being, at the recent State Society Meeting, in view of the fact that plans of a national scope are in process of contemplation and which, if adopted, will supersede the plans upon which the New Jersey State Medical Socicty has been working for the past several years.

The Secretary of the committee appointed to study the features of Emergency Medical Relief, Dr. J. Howard Hornberger, reported that every physician in Burlington County had been provided with a set of regulations as dictated by the State Emergency Relief Committee in conjunction with the State Medical Society Committee appointed for this purpose, together with the interpretations thereof as approved by our County Relief Commission, and as applying to conditions in Burlington County, as well as a registration card permitting those who signed them to participate in this work. Dr. Hornberger reported that 74 of these had been sent out, and that 62 had thus far been returned. The returns are probably still incomplete, because some of the physicians of the county have not as yet returned from vacation. The committee feels that the program as outlined by the State authorities should be subject to some revision in certain details, among them being the fact that no provision is made for additional charges for night calls. The committee also feels that emergency operations performed in physicians' offices: such as ligation of blood vessels; or other emergency procedures necessitating attention before a patient can be taken to a hospital, and where it is perhaps inadvisable to move a patient to a hospital because of hemorrhage or shock; should be reimbursed at a rate more commensurate with the seriousness of the condition than a mere office fee. There are also other procedures, such as paracentesis of an ear drum, which are not of sufficient magnitude to

always warrant hospitalization, yet which are deserving of more remuneration than provided for by a mere house or office fee. The committee also feels that where physicians do laboratory work, x-ray or physiotherapy treatments in their offices, the sum of $1 is totally inadequate for the services rendered. The committee is also of the opinion that the regulations must have been drawn up by individuals notoriously uninformed of eonditions as applying to rural practice. When a physician has to travel 20 miles one way to see a patient, and sometimes, in inclement weather has to walk the last mile because of quick-sands or other impassable road conditions, a fee of $1.50 or $2 is nothing more or less than ridiculous. It is hoped that the authors of these regulations in effect will become cognizant of the fact that not all of the physicians in the State enjoy the luxury of urban practice.

Dr. Charles S. Shapiro, of Maple Shade, was elected to membership in the society, and it is the wish that his affiliation with Burlington County Medical Society be mutually profitable and pleasant. The Society also welcomes to its membership, Dr. W. Fred Lucas, formerly of Jersey City, whose membership was transferred to our society at this meeting.

There being no further business, the meeting was turned over to the chairman of the scientifie section, Dr. Eugene A. Meyer, of Moorestown, who introduced as the speakers of the day, Drs. Temple Fay, of Philadelphia, and H. Wesley Jack, of Camden, who presented a most significant and illuminating symposium on "Head Injuries". The faet that the scientific portion of the program occupied about 2 hours is evidence of the masterly presentation of the orators and the interest they evoked among their audience. The society is intensely grateful to these gentlemen doctors and to Dr. Meyer, who procured them as speakers, for their helpful and timely papers.

The meeting was adjourned at 5.15 p. m.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

Resuming activity following the Summer vacation period, the Gloucester County Medical Society met September 22, at the Hotel Pitman.

An address by Dr. B. F. Buzby, of Camden, on "Osteomyelitis" was unusually interesting and instructive. Members of the society joined in a general discussion following Dr. Buzby's address.

Dr. Ireland, Director of the State Department of Public Instruction, also addressed the physicians.

Announcement was made that the annual social session of the society would be held October 19, with the place to be announced later.

Following the meeting, members of the Auxiliary joined the doctors at a buffet supper.

Members present were: Drs. William Pedrick and Charles Pedrick, Glassboro; William E. Crain, C. A. Bowersox, Paul M. Pegau, Ralph Moore, E. E. Downs, J. Harris Underwood, Henry B. Diverty and Fuller G. Sherman, of Woodbury; I. W. Knight, M. F. Lummis, W. P. Chalfant, Thomas L. Sooy and W. J. Burkett, Pitman; T. M. Gairdner and C. I. Ulmer, Gibbstown; Don Weems, Wenonah; B. A. Livengood, Swedesboro; F. G. Wandell, Clayton; Horace M. Fooder, Williamstown; A. B. Black, Mickelton; S. F. Ashcraft, Mullica Hill; H. L. Sinexon, Paulsboro, and Ralph K. Hollinshed and E. P. Ristine, Westville. Guests included Drs. Ireland, of Trenton, Buzby and E. G. Hummel, of Camden.

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

The Annual Meeting of the Morris County Medical Society was held the evening of September 21 at the New Jersey State Hospital at Greystone Park, with President Pinckney presiding and about 50 in attendance.

Routine business was transacted, which included proeeedings of meetings of the Executive Committee, among which were references to recommendations to the Morris County Board of Chosen Freeholders for the appointment of a County Physician with the necessary qualifications with an urge that the Society's recommendations be given due consideration; also action taken by the Society for the retention and continuance of the outstanding services of Editor Dr. Henry O. Reik, which action has been ratified by several other County Societies.

The recommendations of the Nominating Committee were unanimously approved and the following officers for the ensuing year were unanimously elected: President, Inglis F. Frost; Vice-President, Bernard S. McMahon; Secretary, Albert J. Ward; Treasurer, George J. Young; Reporter, Marcus A. Curry; Historian, H. W. Kice. Additional members of the Exeeutive Committee, Pinckney, Williams and Larson. Member of the House of Delegates of the State Medical Society term expiring in 1936, Costello; Alternate, Carberry. Member of the Nominating Committee of the State Soeiety, 1934, McMahon.

The speaker of the evening was Dr. Richard N. Pierson, of New York City, whose subject was "Miscellaneous Topics of Current Interest in Obstetrics". Dr. Pierson's address was given with ease and interest and drawn from his well stored repository of knowledge and information on the subject in general and his experiences at the Sloan Maternity Hospital in New York. The address was well received and emphasized the importance of clinieal judgment. Discussion was entered into and questions asked by Drs. Williams, Frost, Johnston, McMahon and others. All points brought up were fully answered by Dr. Pierson and at the conclusion he received a rising vote of thanks and appreciation for providing an exceptionally interesting evening.

Retiring President Pinckney expressed his very great p'easure in having had the opportunity to work for and with the members and officers during the past year and expressed his appreciation of the coöperation he had enjoyed. He sounded a note of regret that at some of the meetings there was not so large an attendance as was hoped for, mentioning that being so close to New York it has been difficult to organize any definite group of lectures in Morristown as so many feel that if they wish to take up some specialty in which they are particularly interested they can conveniently arrange for it in New York; therefore the Executive Committee has tried to select men who would bring to the Society subjects of interest to as many members as possible; that he thought it was up to the members to attend these meetings and encourage the attendance of other members.

Newly e'ected President Frost was invited to the chair by Dr. Pinckney, who turned over to him the presidential seat for the ensuing year. President Frost outlined an interesting program of monthly meetings for the year and indicated a fine list of speakers and invited any member interested in some particular subject not scheduled to make his wishes known and effort would be made for its inclusion; also impressing the importance of as near 100% attendance for the coming year as possible.

Under the head of new business, Dr. Larson invited action of the Society as a whole in supporting the recommendations of the Committee to the Morris County Board of Chosen Freeholders that the County Physician to be appointed should be properly qualified and be a pathologist to perform the duties set forth in the enabling Act. This proposal was unanimously carried.

At the close of a very interesting meeting from the standpoint of internal affairs of the Society and the splendid address of the speaker of the evening, adjournment was taken and refreshments enjoyed.

Obituary

OWEN, Frederick Wooster, M.D., died of pneumonia at his home, 18 Franklin Place, Morristown, on August 25, in his ninety-third year.

Dr. Owen was Morristown's oldest and one of its most beloved physicians and his loss will be keenly felt by the host of friends to whom he had greatly endeared himself during his many years of medical service in this town.

Dr. Owen was born October 6, 1840, at Vineyard Haven, Massachusetts. He was the son of Captain William Wilson Owen, of Bath, Maine, and Adeline Wooster Owen, of Middle Island, Long Island, New York, and had a fine patriotic American ancestry on both his father's and mother's side.

When a young child he was placed in French and German schools and quickly learned to speak these languages fluently because of his rare linquistic gift.

At 15 years of age he went to Europe for 4 years of academic work, studying in the Gymnasia of Neuchatel, Switzerland, and in Leipzig, Germany.

Dr. Owen was among the first to go to the front at the call of President Lincoln in 1861 and was rapidly promoted from Ensign to First Lieutenant and he served thus in the Signal Corps the greater part of the war. Later he was promoted to Captain in the Commissary Department. After 3½ years of arduous military service he was honorably retired on "a surgeon's certificate of disability", having contracted typhoid fever and for several weeks his life hung by a thread, as 2 faithful Signal Corps privates nursed him back to life while on a gun-boat on the Potomac.

He was later awarded the honorary distinction of Brevet Lieutenant-Colonel of New York Volunteers, being recommended for this honor by Colonel Albert Meyers of the Signal Corps of the United States Army.

After the Civil War, Dr. Owen became Chief Clerk of the Freedman's Bureau in Washington under General O. O. Howard, and also pursued his medical education, graduating in 1867 from the Medical Department of the University of Georgetown.

In November, 1867, he married Louisa Graves, eldest daughter of Rufus R. and Mary Jane Graves, of Brooklyn, New York.

In 1869 Dr. Owen was graduated from the Medical University of Paris, France.

After a term as Adjunct Surgeon in the Long Island College Hospital, he came to Morristown, New Jersey. Here he practiced medicine for 40 years, retiring from professional life at the age of 70. He was the friend of all, especially perhaps of children and of those who needed help, and it was a frequent pleasure to him to lessen his fees to those to whom they might be a hardship. He was a Companion of the Military Order of the Loyal Legion of the United States and was a member of the Sons of the American Revolution. Until recent years Dr. Owen was for some time adjutant of the local Torbert Post of the G. A. R. He was a Director and Trustee of the Morristown Library and for 17 years he acted as visiting physician of All Souls Hospital in Morristown, and was also a consulting physician on the Staff of the Memorial Hospital.

He was a member of the Academy of Medicine of New York and a member of the Morris County and New Jersey State Medical Societies.

Dr. Owen continued keenly interested in many activities in his church and in Morristown until he was stricken by an attack of angina pectoris on December 4, 1929. For nearly 4 years he had been a happy invalid, enjoying his home, family and intimate friends, though within restricted bounds, owing to his very limited strength.

Dr. Owen was not only a loyal soldier at the call of his country, but even more a loyal soldier of the Cross of Christ. He became a Christian through the agency of the Y. M. C. A. in Washington and he could not rest until he had interested several of his friends in aiding him in establishnig a Y. M. C. A. in Morristown.

His friends and neighbors will remember Dr. Owen for his kindness of heart, his keen sense of humor and his tremendous and worthy loyalties.

The beautiful promise of Psalm 91-16 seems especially like a benediction upon his life: "With long life will I satisfy him and show him my salvation."

Dr. Owen is survived by his 2 daughters, Miss Adeline W. Owen, of Morristown, and Mrs. Frederick P. Mudge, of Sparta. Dr. Owen's wife, the former Louisa Graves, died several years ago.

RUFE, John J., M.D., of High Bridge, died at Easton Hospital, Easton, Pa., August 17. The cause of death was septicemia. He had, in fact, been troubled with an affection of the kidneys ever since the flu epidemic of 1918, when he was critically ill. He was subject each Winter to recurring attacks of grip but he attended all calls of his patients regardless of his own physical condition. His practice was so extensive that he was kept on the go day and night. During the 29 years that he practiced here he officiated at nearly 1200 births.

Dr. Rufe, who was 55 years old, was born at Revere, Pa. He was a graduate of the Stroudsburg High School and of Jefferson Medical College, Philadelphia. He located in High Bridge in 1904 and 3 years later, on June 26, 1907, married Miss Helen Heffernan, of High Bridge. She survives him with 2 sons, John and Mark Edward. He also leaves a brother, Dr. Edward Rufe, a New York dentist, and a sister, Mrs. George Swank, of Raubsville, Pa. His only lodge connection was with the Knights of Pythias.

Father W. J. Lannary officiated at the funeral. The church was unable to accommodate the people who attended, despite the rain, and the floral tributes were extensive. Tributes came from friends at long distances and these, with the numerous friends that called at his home indicated the high regard that the community held for the deceased physician.

The following doctors served as pallbearers at the funeral: B. S. Furhmann, of Flemington; Theodore Fulper, of Hampton; A. H. Coleman and I. R. Boothby, of Clinton; C. G. Boyer, of Annandale, and E. D. Trimmer, of High Bridge.

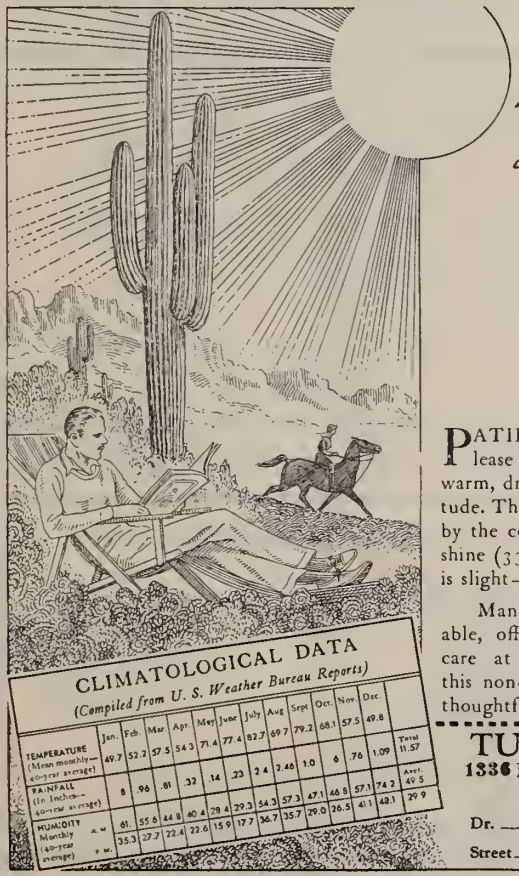
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	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	
TEMPERATURE (Mean monthly—40-year average)	49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8	Total 11.57
RAINFALL (In inches—40-year average)	8	.96	.81	.32	.14	.23	2.4	2.48	1.0	.6	.76	1.09	Aver. 49.5
HUMIDITY Monthly (40-year average) a. m.	61.	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.1	44.8	57.1	74.2	29.9
p. m.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1	68.1	

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NRA AND THE NURSING PROFESSION

In the spirit of the times the Board of Directors of the American Nurses' Association has advised its membership, numbering approximately 90,000, how they may coöperate with the principle of the NRA.

The registered nurse as a member of a profession is not covered by a code. The needs of the sick patient are the first consideration of the nurse and the ideal upon which nursing as a profession is built. However, the entire citizenship of the country has been urged to coöperate in a policy which in general is applicable to professions, particularly that of nursing, since, quoting President Roosevelt, "the essence of the plan is a universal limitation of hours of work per week for the individual *by common consent*".

Because the hours of duty have been unduly long, from the inception of skilled nursing, as relates both to the welfare of the patient and to the individual nurse, the officers of the American Nurses' Association recommend that "in the interest of good nursing we believe that nurses in caring for acutely ill patients should not be expected to work more than 8 hours out of 24. This service is to be arranged wherever and whenever possible without added expense to the patient."

It is further recommended that "an attempt should be made to approach reasonable working conditions by encouraging, wherever possible, in the interest of the patient as well as the nurse an 8-hour day for those employed on a daily basis and a 48-hour week for those employed on a weekly or monthly schedule. It is undoubtedly desirable to shorten the hours of duty so that the individual nurse may have a reasonable working day, and also that there may be a spreading of work." The 8-hour plan for special duty already in successful operation in several sections of the country, insures adequate skilled nursing care for the patient, and in addition, serves to materially increase employment among nurses.

One of the principles named in the implication of the National Recovery Act to the nursing profession by the American Nurses' Association Board of Directors was that "no plan for economic recovery in this country will be complete without taking into consideration the matter of the thousands of graduate registered nurses who are unemployed at the present time, due to over-production, unequal distribution, and the general strained economic conditions prevailing".

It is believed that the public will realize the advantages to be gained, both by the patient and the nurse and by "common consent" will assist in securing for registered nurses reasonable hours comparable with those which have been enjoyed in other professions for a considerable time. In this way, the nurse will be enabled to maintain the ideal for the best possible care of the patient and through the spreading of employment to coöperate with the spirit of the NRA.

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N. J. CANCER DEATHS DROP

Although the death rate from cancer and other malignant tumors increased in 30 States from 105.6 per 100,000 population in 1931 to 108.5 in 1932, New Jersey was 1 of 5 States showing a decrease in mortality from this disease, according to an article in the Statistical Bulletin, published by the Metropolitan Life Insurance Co.

The 30 States included in the survey comprise 47% of the population of continental United States. New Jersey's death rate from cancer in 1931 was 112.2 per 100,000. In 1932 it dropped to 111.0, a decrease of 1.1.

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E. R. Mulford	"	"	1935
A. Haines Lippincott	"	"	1935

Alternate Delegates

Philip Marvel	Term expires		1934
George H. Sexsmith	"	"	1934
S. B. English	"	"	1935
Stephen T. Quinn	"	"	1935

SCIENTIFIC SECTIONS

Chairmen for the Annual Meeting of 1934

Section	*Chairman*
Eye, Ear, Nose, Throat	S. T. Hubbard, Hackensack
Pediatrics	Walter B. Stewart, 8 N. Tallahassee Ave., At. C'y
Radiology	C. B. Kaighn, 905 Pacific Ave., Atlantic City
School Physicians	A. G. Ireland, Trenton Trust Bldg., Tr'n

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Louis C. Lange, *Chm.,* Weehawken	Term expires		1934
Ralph K. Hollinshed, Westville	"	"	1935
Clarence C. Andrews, Atlantic City	"	"	1934

Committee on Publication

Henry C. Barkhorn, *Chm.,* Newark	Term expires		1936
Edward J. Ill, Newark	"	"	1934
Linn Emerson, Orange	"	"	1935
Frederic J. Quigley			Ex-officio
J. Bennett Morrison			Ex-officio

Committee on Finance and Budget

Harry R. North, *Chm.,* Trenton	Term expires		1939
Alfred Stahl	"	"	1934
James S. Green	"	"	1935
Herschel Pettit	"	"	1936
William G. Herrman	"	"	1937
William J. Sweeney	"	"	1938

Committee on Program and Arrangements

William J. Carrington, *Chm.,* Atl. City	Term expires		1935
John W. Gray, Newark	"	"	1934
William D. Olmstead, Atlantic City	"	"	1936
Frederic J. Quigley, Union City			Ex-officio
J. Bennett Morrison, Newark			Ex-officio

Committee on Honorary Membership

Thomas W. Harvey, *Chm.*	Term expires		1934
W. E. Darnall	"	"	1935
Ephraim R. Mulford	"	"	1936

Committee on Hospitals and Medical Education

Harry H. Satchwell, *Chm.*	Term expires		1936
William W. Brooke	"	"	1935
Arcangelo Liva	"	"	1934

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Charles H. deT. Shivers
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(To be announced)

HISTORY OF ARTIFICIAL PNEUMOTHORAX

"A History of Artificial Pneumothorax in America", which will run in 5 installments, begins in the September number of the Journal of the Outdoor Life (National Tuberculosis Association). The series is by a well-known physician who has spent more than 3 years in gathering and compiling the material.

The comparatively recent rise of surgery in the treatment of tuberculosis has focused the attention of both tuberculosis specialists and of general surgeons on this method. The series of articles traces the history of the use of artificial pneumothorax from the very first mention of this method of treatment in America, made in a communication written by Dr. Daniel McRuer in 1835 and published in the Boston Medical and Surgical Journal. Naturally, much stress is laid on the paper read by Dr. John B. Murphy, of Chicago, in 1898 at the Denver meeting of the American Medical Association. The unfortunate conflict on priority between Murphy and Forlanini is also discussed and the strange lapse of interest for a decade following the death of Lemke, Murphy's associate, in 1904, is graphically recited. The author then comes down to the more recent developments during the first 2 decades of the present century and brings the history to the present time.

Copies of the Journal of the Outdoor Life for 6 months, beginning with the September number, may be secured through the National Tuberculosis Association, 450 Seventh Avenue, New York City, by advance subscription of 50 cents.

HOSPITAL AWARD FOR ORANGES FEDERATION

(Newark Evening News, Sept. 8)

Announcement was made by the Hospital Week Contest Committee of the American Hospital Association of the awarding of third place in the annual international competition to the Welfare Federation of the Oranges and Maplewood. Other awards were not announced. The purpose of the contest was to stimulate interest in hospitals through Hospital Week, which included May 12, the birthday of Florence Nightingale.

The award was given the Federation because of its success in bringing together in a common project the 4 hospitals of the Oranges and Maplewood, the Orange Memorial, St. Mary's, New Jersey Orthopedic and the Essex County Homeopathic Hospital, a nonmember of the Federation.

The committee included representatives of the 4 hospitals with G. Clifford Jones, Publicity Director of the Federation, as Chairman. The award will be made next week at the annual convention of the American Hospital Association at Milwaukee. The contest has been conducted for the last 15 years and includes cities in every State, Canada and several other countries.

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Owing to repeated requests from leading physicians and surgeons in Greater New York, Amsterdam Brothers recently opened a new shop at 150 East 53d Street, New York City.

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The Secretary of the Component Society should promptly notify the Recording Secretary of the Medical Society of New Jersey and the Editor of the Journal of any error or change in these offices.

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OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 11 Orange, N. J., November, 1933 Subscription, $3.00 Per Year Single Copies, 30 Cents

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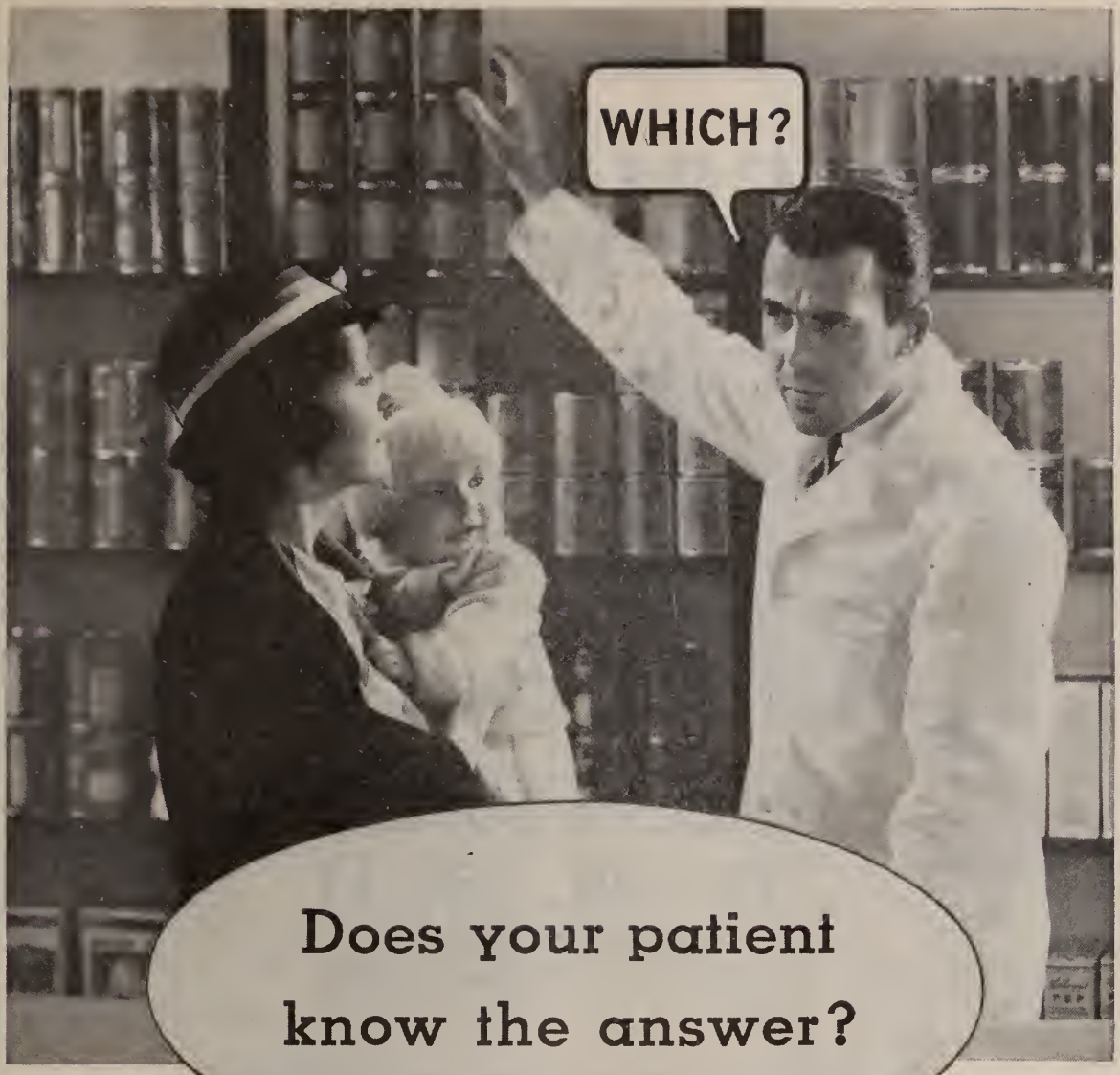
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Journal of The Medical Society of New Jersey

Published on the First Day of Every Month

Under the Direction of the Committee on Publication

Address all communications to 45 Johnson Ave., Newark, N. J.

Vol. XXX., No. 11 ORANGE, N. J., NOVEMBER, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

Editorials

A MESSAGE FROM YOUR PRESIDENT*

FREDERIC J. QUIGLEY, M.D.

As President of the Medical Society of New Jersey and the elected leader of organized medicine of this State, I deem it my duty and responsibility to advise this committee of my judgment as to the policy and program which should be pursued by the Society during my administration.

Today, the dominant problem of the medical profession, like that of the rest of the nation, is economic. The length and severity of the depression, coupled with other factors with which we are all familiar, have focused the attention of the profession, in a manner and degree heretofore unknown, on the major disabilities and handicaps besetting the practice of medicine—evils which have been steadily growing even during the past so-called prosperous years.

Our major economic problems may be listed as follows:

(1) The excess of physicians to population.

(2) Free medical care.

(3) The corporate practice of medicine
  (a) by the State
  (b) by private corporations.

EXCESS OF PHYSICIANS

Steps have been taken during the past year, through the initiative of the Council on Hospitals and Medical Education of the American Medical Association, which will sharply decrease the number of future graduates of medical schools of this country and drastically curtail the number of licentiates from foreign schools.

STATE MEDICAL POLICY

To deal effectively with the major problems adversely affecting the practice of medicine, calls for a continuous policy on the part of the Medical Society of New Jersey. The steady objective of this policy will be to improve the status of the doctor, particularly his economic status, so that he may be in a better position to render improved medical care to the public.

The essential need of such a continuing policy on the part of the Society appeals strongly not only to me but also to the President-Elect, Dr. Ely, and to the First and Second Vice-Presidents, Drs. Newcomb and Haussling. My colleagues will advocate the continuance of such a policy in the event of their succession to the presidency.

Before considering further the major economic problems confronting the profession, let us direct our attention for a moment to the National Recovery program now going forward. The larger purpose of this program is to insure greater social and economic justice to all the people of the nation. The National Recovery Act, deemed necessary to rehabilitate industry, provides for the formulation of codes by the industries affected, in which unfair trade practices and unfair com-

*(Address to Welfare Committee of the Medical Society of New Jersey, October 15, 1933.)

petition are defined and proscribed. The professions, for the most part, are exempt from the provisions of the National Recovery Act, but if the principle of relieving industry of unfair trade practices and unfair competition is sound, the application of this policy to the rehabilitation of Medicine is equally sound. We have as much right as any other group to participate in a national program of recovery; we have an equal right to freedom from exploitation, and the right to economic justice.

The measures now under way for national recovery represent an about face from the do-nothing policy, the inertia and lethargy of the preceding years. In like manner, we, too, rousing ourselves from our apathy, and from a policy of drift and laissez-faire, must institute and vigorously promote a policy of sustained effort that aims to improve the status of the doctor.

Free Medical Care

We shall now consider the second major problem, viz: the question of free medical care. This is undoubtedly the outstanding problem of the profession. Many of us, probably most of us, in ordinary times, would still like to retain our time-honored right to treat the indigent free. For the past 3½ years, indeed until 3 or 4 months ago, the medical profession of this State has borne, practically unaided, the tremendous economic load of providing medical care to an unprecedented number of people, unable, because of the severity and length of the present depression, to pay for this service. The Emergency Relief Administration, realizing the enormous load the profession had been carrying, offered to partially compensate the profession for the care of E. R. A. clients as an emergency measure.

The plan agreed upon by the Medical Society of New Jersey and the E. R. A., lately put in operation, provides a sound set-up, incorporating principles vital to the profession, for the care of indigents *during the emergency*. For the time being, this is definitely part of the Society's program, and it is pertinent to call attention to the fact that if it subsequently becomes necessary to insist that the State relieve the profession of the care of the indigent, as a permanent policy, the present plan need only be continued and extended. It possesses, we believe, all the provisions and safeguards which the profession believes desirable and necessary.

The abuse of medical charity on the part of hospitals and clinics must be curtailed if we are to continue to treat the indigent free. As the doctor is the only element in the hospital that *gives free service,* he should in largest measure have the right to determine the policies governing free care. To insist that staffs of hospitals have as much responsibility as the governing bodies in the establishment and operation of the policy of free medical care, is simple justice.

The whole subject of staff relationship to hospitals is now being studied by the Sub-Committee on Hospitals of the Committee on Hospitals and Medical Education, and this committee will report to the Trustees, we hope within a short time, as to requirements and standards that shall govern the relationship of members of this Society to hospitals. With the inauguration of requirements and standards incorporating sound principles of staff relationship, we hope to see an amelioration of hospital and clinic abuses.

Corporate Practice of Medicine

The third problem—The Corporate Practice of Medicine—is divided into 2 parts: Practice of medicine (a) by the State, and (b) by private corporations, more commonly referred to as Contract Practice. The rapidly expanding field of preventive medicine, and the fact that much of this work is now arrogated by Health Departments and clinics, makes necessary a program which will recapture and return to the doctor's office as much of this work as possible. The comprehensive program of the Public Health Committee, adopted at the last Annual Meeting and augmented since, aims to do this by coördinating all health activities under medical supervision through the medium of the county medical societies; and hopes through coöperation of county medical societies and local health departments to work out the other objectives of this program.

Endeavor should be made to improve the Workmen's Compensation Act, in order to insure freer choice of physicians than now prevails. Present abuses and inequities in the operation of the Act should be eradicated.

Whether it will be possible to effect these improvements by negotiations with the carriers, or whether additional legislation will be needed, is yet to be determined. Some work has been done on this subject during the Summer, and report thereon will be made at this meeting. It must be remembered that the Workmen's Compensation Act was not drawn in the interest of the employer, the insurance carrier or the medical profession, but solely in the interest of the injured workman. All changes, therefore, in the nature and operation of the Act must be considered from the viewpoint of the injured worker. However, we are of the opinion that there is considerable room for improvement in the operation of this Act. Before dismissing this subject, reference should be made to the fact that the Medical Society of New Jersey, in 1922, went before the Legislature and succeeded in removing the $50 limit for medical and hospital services in any given case; this change in the law was distinctly beneficial, both to the injured workman and to the doctor. The interpretation of the Act was further liberalized by the Commissioner of Labor, who was a physician.

It may not be amiss, inasmuch as we now propose the introduction of legislation in behalf of the profession, to recall that in the years 1921-23, 2 other notable pieces of legislation, of direct and positive benefit to the doctor, were enacted into law through the efforts of this Society. In 1921, the "Limited License Act" was passed, making it necessary for those applying for this type of license to possess more adequate educational qualifications. In the previous year, the Chiropractic Board, which this Act wiped out, licensed 597 chiropractors in this State. In 1923 a Bill was passed which drove out of the State the many "quack" and "cult schools" then infesting it. These measures, all passed within a brief period, evidence the fact that this Society *can,* if it *wills* to do it, secure the passage of necessary legislation.

The question of Contract Practice, always a bug-bear to the profession, is causing added concern, at the moment, by reason of various experiments recently projected, such as certain types of group practice, hospital insurance, et cetera. All the varied and newer types of contract practice should be considered by some agency of the Society with power to sanction or disapprove. Both their immediate results and their ultimate effect on medical practice should be considered. There seems a genuine need for this committee to create a sub-committee on "Medical Practice", to which could be referred subjects such as these or of a kindred nature.

The Profession and the Legislature

The present "hospital lien law" should be amended, at the 1934 session of the Legislature, if possible, to include liens for medical and surgical services rendered in public liability cases.

Every year the Legislature is importuned by various cults insistent upon exchanging their lack of education for legislation. The Society, through its Welfare Committee, is obliged year after year to combat this inimical legislation. That no enactments of this nature have passed in recent years is due to the efforts of 4 members of the profession in the Legislature. There is present reason to believe that the legislators might view sympathetically the introduction of a Bill that would set up a single standard of medical licensure for all those wishing to practice the healing art.

Several years ago there was introduced in the Legislature, by this Society, an Act which would have limited the use of the title "Doctor" and "Dr." (with the exception of holders of academic degrees) to graduates of medicine. This Bill passed the Senate 2 successive years, and then further efforts to pass it were abandoned. The year after the introduction of this measure in the New Jersey Legislature, the New York Medical Society obtained the passage of a similar bill in that State. This bill, modeled after ours, is now part of its Medical Practice Act. New York has had ample time to gauge its benefits, and the consensus of those competent to judge is that this measure has been the most vital single factor in curtailing quackery in that State.

It is recommended that this committee promptly undertake the drawing of a Bill which shall set up a single standard of medical licensure and which shall limit the use of

the title "Doctor" or "Dr." to graduates of medicine. This measure should be introduced in the Legislature, either this year or next, as seems expedient.

The objectives of the program advocated may be summarized as follows:

Through the Public Health Committee: To coördinate all medical activities in the various counties under the supervision of the county medical societies; and to recapture and return to the doctor the rapidly enlarging field of Preventive Medicine.

Through the Committee on Hospitals and Medical Education: To establish a sound staff relationship to hospitals and a sound policy as to free care of patients in hospitals and clinics; and to eliminate unfair competition by hospitals and clinics.

Through the Welfare Committee:

(1) Improvement in operation of the Workmen's Compensation Act and, if necessary, amending the Act to provide for freer choice of physicians.

(2) Amendment to the present "Hospital Lien Law" to include liens covering physicians' fees in liability cases.

(3) Legislation providing a single standard for licensure and limiting the use of the title "Doctor".

(4) Regulation and supervision of contract practice.

Epitomized, the continuing policy of the Society should be directed toward *improving the status of the doctor, particularly his economic status,* in order that he may be in a position to render better service to the public.

SUMMARY OF THE REPORT OF THE PUBLIC HEALTH COMMITTEE

(See Official Transactions September 1933, Page 27)

Specific plans have been made for the assumption of public health leadership by the organized medical profession of this State, by 2 methods:

(1) By having the Medical Society of New Jersey, through its Component Societies, undertake 2 definite pieces of child health work.

(2) By having the State and County Societies link to themselves the various health services and agencies, by requesting their aid in the accomplishment of these definite pieces of health work.

In June 1932, the Committee presented the following resolutions which were adopted by the Medical Society of New Jersey concerning: (1) State Board of Health; (2) the relation of physicians to child health activities; (3) relation of physicians to school health matters; (4) relation of physicians to hospitals and hospital clinics; (5) relation and coördination of physicians with health and welfare organizations.

* * * * * * *

(2) *Resolved* that: (a) Physicians should be in attendance at every type of diagnostic or consultation station, whether it be for adults or children. (b) Physicians should be paid for such work. (c) Communities should be educated to an understanding that these services are not to replace the private physician but are for those only who cannot afford to pay a doctor. (d) This program should be carried out through friendly cooperation with organizations and public health authorities by the Public Health Committees of the State and County Medical Societies.

(3) *Resolved* that: (a) *All School Clinics* should be discouraged. Immunization against diphtheria, vaccinations, surgical, dental and eye clinics, and others, should all be discouraged, because of the danger of abuse of such clinics, and for the more important reason that such clinics should be relegated to their proper place—the hospital. In the rural districts, where there are no clinical facilities, the County Societies should make such provision for indigent pupils as may seem most expedient. (b) All pre-school examinations and treatment should be done by the family physician. Immunization against diphtheria, and vaccination, should be done for all children during the first year of life, since it has been shown that 3/5 of all diphtheria cases in children occur before they are 5 years old.

(4) In view of the special problem created by the increasing number of persons availing themselves of free dispensary and hospital service who can afford to pay for medical service, and following the recommendation of the American College of Surgeons, that a definite system of determining the social sta-

tus of the patient in relation to eligibility should be established, it is—

Resolved: that the State Society emphasize the necessity of developing a Social Service Department in connection with every hospital in the State, and, furthermore, that this phase of the work be delegated to the Woman's Auxiliary to the State Society.

(5) Regarding the Relation and Coördination of Physicians to Health and Welfare Organizations, the following *Principles* are suggested:

Principle 1. In order to establish a working relationship and coördination between physicians and health and welfare organizations, there must be created State and County Committees, or Councils, composed of the executive officials of the health and welfare organizations, with regular meetings to accomplish such coördination.

Principle 2. All public health or welfare work of a medical nature performed by physicians, members of the State Medical Society, shall be on a salary basis, except during a limited initial period for demonstration value of such work.

Principle 3. Public or private organizations, and physicians doing health work of any character, shall administer such work so that all persons will be assisted in obtaining health facilities in direct proportion to their financial ability to carry their own responsibilities in this respect.

In view of the above enumerated principles, your Committee recommends the following resolutions:

(1) That State and County Committees, or Councils, be formed, composed of the executive officials of the State and County Medical Societies, together with executive officials of the Health and Welfare Organizations, for the purpose of holding regular meetings and coördinating their work.

(2) That the time has come for the State and County Medical Societies to assume leadership and responsibility for the general health of the citizens of New Jersey, and thereby to preserve the personal and private relationship between physician and patient, which is most desirable for the health needs of the patient.

This year our Committee offers the following resolutions:

(1) *Resolved* that our State and County Societies put into effect the resolutions enacted last year, through definite action in each County Society, by its Public Health Committee, on public health matters covered by the resolutions.

(Our State Committee offers the service of its members in an advisory capacity to the County Societies as to definite plans whereby these resolutions can be carried into effect in the various Counties.)

(2) *Resolved* that, as a definite step in the application of the *Principles* adopted in June 1932 by the Medical Society of New Jersey, regarding leadership by the medical profession in health matters, the State and County Societies undertake the Diphtheria immunization of babies and children between the ages of 6 months and 6 years, preferably before the age of 2 years.

(3) *Resolved* that the State and County Societies sponsor and undertake *health supervision of the pre-school child,* by the bi-annual examination of the child between 2 and 6 years of age, by the family physician, his findings to be recorded on the "New Jersey Pre-School Record Form". (Note: The physician shall be paid for this service.)

(4) *Resolved* that the State Society assume responsible health leadership, by directing its component Societies to immediately appoint County Society Health Service Committees, or similar bodies, to be composed of its leading public health minded physicians, and representatives of all health agencies, now existing, in each County, for the *stated object* of "providing by *existing health agencies,* adequate medical care, for all people in each County, at *costs within their means*".

Respectfully submitted,
Wm. G. Schauffler, Chairman*
J. Shapiro
Stanley H. Nichols, Secretary
F. C. Johnson
Julius Levy
Allen G. Ireland

*Deceased.

PUBLIC HEALTH COMMITTEE MEETING

On Tuesday afternoon and evening, October 3, in the Academy of Medicine at Newark, Dr. Henry F. Vaughan, Health Commissioner of Detroit, addressed 2 audiences of medical men, practitioners and health officials together with others interested in the subject of medical participation in community health programs.

Dr. Vaughan told of his experiences in his own city and the gratifying results obtained through the coöperation of the county medical society, the city health department and the hospitals. Credit was given to the dental practitioners and other allied health groups for their coöperation and support.

The necessity for a well organized health department in such a program was emphasized, but to the fine spirit of the private physicians was credited the success of the Detroit plan, which Dr. Vaughan modestly protested was not to be referred to as the "Vaughan Plan".

"An Experiment in Medical Participation in a Community Health Program" was the title by which Dr. Vaughan characterized the work in his city. He said that after 7 years trial no one in his city cared to give up the program and the city officials feel that the money spent in its development is well invested. Diphtheria immunization was greatly increased, but this was a by-product of his work as he believed the plan can be applied to both preventive and curative services of broader scope, extending to other communicable diseases such as tuberculosis, venereal diseases and also to such chronic disease problems as cancer.

The participation of the private physician through plans worked out coöperatively by his medical society and industry is also being developed in Detroit according to Dr. Vaughan. Since it is the physicians who furnish the essential medical service it must always be under the control of the medical society.

Both reports of the Committee on the Costs of Medical Care stressed 3 essentials which Dr. Vaughan claims are met by the Detroit Plan. (1) Group insurance (taxes for indigent relief). (2) Group practice (medical society). (3) Improvement of medical service (medical society, post-graduate education).

The outcomes of the Detroit experiment are given as follows: (1) Elimination of paternalism; (2) Re-emphasis on parental responsibility; (3) Better medical service; (4) Better health protection.

The constant criticism made by physicians has been chiefly constructive and most helpful in adjusting the procedure.

Dr. Vaughan gives as the essentials in such a plan: (1) Adequate preparation of the private physicians through education and participation. (2) Organized attack upon the problems. (3) Enlistment of public understanding and support.

Due to the special character of the city of Detroit with its large mobile population, 40% of the newborn are for various reasons out of the city before the end of the first year; still the plan accomplishes the immunization of 60% of the total registered births within the first year of life (beginning at 6 months of age). This record is far in excess of former achievements.

At designated hours, the doctors participating in the plan charge a fixed fee of one dollar per injection; however, they are free to make their usual charge at all other hours.

The city pays the physician an honorarium of fifty cents in case of indigents and the physicians decide upon the eligibility for "free" service.

The Kellogg Foundation of Michigan is contributing to an experiment with a similar plan in 3 counties of Michigan, in an endeavor to adapt the principles of the Detroit Plan to rural conditions.

In the discussions which followed Dr. Vaughan's presentation, accredited representatives of the Medical Society, State Department of Health, city and suburban departments of health, district health officers, county health officers and governing officials asked many pertinent questions which Dr. Vaughan answered according to his own ideas and experience.

The evening meeting was open to the public and was illustrated with lantern slides which showed the procedures and the results obtained.—LeRoy A. Wilkes.

ORIGINAL ARTICLES

MEDICAL PROBLEMS OF TODAY*
Presidential Address

William H. Areson, M.D.,
Upper Montclair, N. J.

At the outset let me say that I felt honored and flattered upon being elected to be the presiding officer of this society—the largest and the oldest County Medical Society in this State—a Society which can be proud of its record as an exponent of organized medicine.

Accompanying my acceptance of the Presidency was a pledge to devote my time, my thought, my energies to that office, hoping in part to justify the high honor you conferred upon me. This is not one man's job; it is a job needing team work of the highest order; this coöperation I have received to the full from all, but particularly do I wish to express my appreciation to the members of the Council and to the Delegates who did more than their bit to keep our Society on the map.

It is not my purpose to present any lengthy arguments about the problems that have confronted us, and which still do, but I do want to express my thoughts about 1 or 2 matters of interest to medical men.

The Cost of Medical Care

Shortly after the publication of the Wilbur Committee Report on "Costs of Medical Care", your President appointed a committee from this Society, with Dr. David A. Kraker as Chairman, to study that report. The Chairman and I have held many conferences, and we are of one mind as to the uselessness of making a formal report; nor do we at this time feel that this Society should make any attempt at leading. It is our opinion that if the medical profession is to accomplish anything concerning this question, its program should be one of watchful waiting. We feel that whatever is to develop in the way of opposition to the majority report must come from our parent organization, the American Medical Association, which should be powerful enough to initiate and enforce any medical policy.

Until the medical profession can find some way to stabilize our incomes, there can be no such thing as stabilized costs of medical care. We must recognize that an unexpected crisis came upon us, which the ordinary powers and processes of government could not stem. The attitude of the rank and file of the medical profession has been one of restraint, frankness and sympathy; we have lived up to our Hippocratic oath and have made every effort to be fair and just, and we have extended to the utmost; all of this is our contribution to the change in the economic pattern which this country has been undergoing during the past few years.

Of higher and broader importance than any plea set up by any group, is the fact that the progress of medicine from Hippocrates to the present day has advanced along the long and difficult road of justice and charity, of kindliness and science, and let me emphasize that every step has been accomplished, not by compulsion, but by the development of higher standards of conduct among our members, which teaches the simple lesson that advance in all that is good and noble comes not from without, but from within.

In my opinion, the medical profession today represents a responsible ownership, and to accept reports such as this $1,000,000 Report on the Costs of Medical Care would be to place us into an irresponsible ownership, a fundamentally unsafe base upon which to build for the future of medicine.

If one may judge the accomplishments of the business world during the past 2 years, it would seem that the medical profession had shown as great ability to take care of its own business as has any other profession. Again considering the cost of medical care, do not forget that a great deal of the increase can be laid to hospitalization; we are all only too fa-

*(Read at the Annual Meeting of the Essex County Medical Society, October 12, 1933.)

miliar with the riotous construction of hospitals, many built as memorials, and, as has been said, many built "to tickle the vanity of architects".

The members of the medical profession have shown an admirable patience in adversity, a fine discipline and respect for order. Any inquiries or study by the medical men into defects of the existing economic order have been with a view to the application of remedies within our own organization. To accept the choice of such a plan as suggested by this Wilbur Committee would be a surrender of our rights at a time when there is a great need for courageous action.

When this economic crisis is over, when confidence is fully restored, and when opportunity for all to work is re-established, when we again learn that the fundamental principles of democratic government are still alive, such radical and revolutionary methods of controlling costs of medical care as have been suggested will naturally sink into oblivion.

We are all well aware of the economic change that has gradually been taking place in the medical profession. The unsatisfactory conditions of the practice of medicine the past few years have occasioned more or less free discussion, and these discussions have been growing stronger and stronger, so that it does seem that the medical profession is getting somewhere with its economic problems.

Medical Education

Associated with the question of the cost of medical care, in my opinion, is the present system of medical education, which seems to me too long drawn out and too expensive; it is, furthermore, difficult to reconcile it with the recognized principles of sound education.

The aim in medical education is the same as in any other branch of education: to make the student keen-witted and intelligent, to stimulate a spirit of inquiry and develop the faculty of scientific reasoning, to encourage curiosity and logic, which in the medical student must be directed toward the study of the human body as a whole and of the bodily processes in health and in disease.

So many new subjects have come to claim the jaded attention of the medical student during the last few years that the prime purpose of his education has been buried out of sight. This was well put recently by one of the Professors of McGill University, who said, "When a medical student must be converted into a physiologist, a physicist, a dentist, a biologist and an electrician, there is not time enough left to make a physician out of him".

When medical education was more or less commercial, as it was a few years ago, it was necessary for state examining boards to formulate very stringent rules, which forced many of the low grade schools to close; but with the improvements that have followed in medical education, many of the requirements might now be rescinded. As suggested by Dean Lewis, Past-President of the A. M. A., schools that are recognized as giving good courses should arrange their own schedules, determine the number of hours which should be devoted to a subject, and graduate the highest type of student; these should be admitted to practice after graduation, without the necessity of a State Board examination.

Dr. Lewis feels that there are certain factors which determine one's ability to practice medicine, not based on studies, schemes, curricula or time schedules.

Cults

A big problem confronting organized medicine today is the perpetual attempt of the different cults to enjoy all the privileges of the medical man without the effort it has cost the members of the medical profession. The survival of our medical practice act is our need, and to this, all our differences and disputes should be subordinated.

There should be freedom for everyone to take whatever course he may desire along the lines of medical teaching, but to practice the healing art, all should come through the same door. There is a great opportunity today for our State Society to fight aggressively and positively for a uniform medical practice act. It is futile, as well as dangerous to our very existence, to sit still and patiently wait for conditions to cure themselves.

We physicians have been focusing our attention more and more on the business side of

medicine, and we have reached a stage, in my opinion, where we should assume the responsibility of a uniform medical practice act. This, of course, has its economic side. We have been very much at sea, and indeed floundering, as to practical ways to meet the situation; this is due entirely to lack of organization and lack of leadership. It is time the medical profession abandoned the defensive and assumed the offensive position in the creation and enforcement of its rights.

State Medical Society

I am of the opinion that new hope lightens the dawn of the coming year for those of us who comprise the medical profession in this State. That hope is inspired by the belief that we are to have a "New Deal" in our State Society, one that under the aggressive leadership of our new President, Dr. Quigley, with the support of his associate officers, will result in a square deal for the medical men of this State.

An important gain was made this past year in throttling the osteopathic bill, but we shall have to make much more progress if we are to hold the ground already won, and that progress cannot be made unless the medical profession improves its organization and unites solidly for its own welfare.

No one is going to help the medical profession permanently except the profession itself; no law can permanently benefit those who will not help themselves, and recognition of this fact will make our profession more inspiring and more cohesive through better organization.

Dr. Quigley and his associate officers of the State Society have a big task confronting them this year, one calling for the full coöperation of every member of the Society. While we all welcome constructive criticism, it should be emphasized that the attempt of any official or any member to exercise arbitrary pressure, or to introduce politics into our State Society, will not only alarm, it will arouse the fighting spirit of all of us who are determined to safeguard the principles of our profession.

Cancer Control

While the workings of my committees this past year have been most satisfactory, and while I am aware of the fact that comparisons are odious, I do want to take this opportunity to acknowledge my appreciation of the work done by the Cancer Control Committee of this Society.

Under the active and constructive plan of its Chairman, Dr. Henry B. Orton, this committee has mapped out a broad program of cancer prevention education and cancer treatment under County control, which, in my opinion, will result in a most valuable contribution by our Society to this perplexing problem.

It was more than 2 years ago that Dr. Orton suggested to me that there should be a County Cancer Clinic established at the Essex County Isolation Hospital at Belleville. While in full accord with him, we were at that time busy with our new building program and therefore did not consider the time favorable for the presentation of this question to the Board of Freeholders.

But now, with an ever-increasing interest in this cancer problem, and in an effort to extend a helping hand to the Cancer Control Committee of this Society, I am prompted to make a few remarks about this question.

It has been stated that in automobiles, telephones, telegraphs, railroads, manufactures, and other necessities of life, the United States leads the world, and it is with some hesitation that I bring to your attention a message from a field in which we are not first, nor second, nor third; in fact, from figures obtained from actuaries, the United States ranks no higher than tenth in the great work of prolonging human life. It is but natural that we medical men pay most attention to those diseases, the causes of which are unknown, and it is safe to say that there are 3 of these which take their places in the first rank, viz., heart disease, diabetes and cancer.

In the present state of medical science, if a person escapes all other diseases he or she will die of heart disease. This danger passed, diabetes is the next hazard. Then if we have good luck in avoiding automobile accidents, cancer

is the final hazard to which a majority of us must yield.

The mortality from heart disease, the leading cause of death since 1922, continues to mount, with the rate reaching the new high point of 157.4 per 100,000. However, the one bright outlook with respect to heart disease is that the rate is declining in the younger ages. This means that such items as medical school inspections, industrial hygiene, and other preventive efforts against disease are bearing fruit, for, while heart conditions cause a death rate late in life, they often begin in childhood or adolescence.

In diabetes we find another increasing death rate, which has risen continuously for 8 years. From well authenticated sources we find an increase in only 2 years of about 25%. But in this disease also we find encouraging signs, for, despite the rapidly increasing death rate, diabetics are living longer today than ever before. The average duration of life in a diabetic has increased materially since the discovery of insulin. We find now that the incidence of the disease is highest in the older age range and that there is a marked drop in the younger age groups.

In contrast with heart disease and diabetes, there does not as yet seem to be any encouraging news about the control of cancer. The fact that each age group above 40 in almost every country for which data are obtainable shows a higher death rate, indicates that there is indeed a real increase.

One of the greatest triumphs of medical and sanitary science is the tremendous decrease in the death rate from tuberculosis in the past 25 years.

Fifteen years ago cancer and tuberculosis claimed the same number of lives annually in New Jersey, but now, as a result of the intensive campaigns carried on all over the world, the tuberculosis death rate has been greatly reduced.

In strong contrast to this, one is confronted with the cancer mortality at the end of 1931, with a 7.4% increase in a single year, and available reports for 1932 indicate there will be an increase of 9% over 1931.

Cancer has been and still is the most mysterious of these 3 unconquered menaces, because we receive no warning of what part of the body machinery has given way. There is probably no disease on which so much experimental and research work has been done in the last decade, and to which so much earnest study is being devoted, as to cancer. Despite this work, the ultimate goal of finding a cure has not been achieved; the cause of cancer is still unknown.

More than 55% of all cancer deaths are from cancer of the digestive organs, and in the majority of these cases the cause is said to be over-eating or the eating of highly spiced foods. To this extent there would seem to be a distinct relation between cancer and modern civilization.

It is estimated that there are 3 living patients for each death, so that probably not far from 500,000 patients in the United States are suffering from this disease today. It has been stated that probably 50% of the present deaths from cancer could be prevented if treatment were undertaken in time.

The Metropolitan Life Insurance Company presents figures which show that of the money disbursed in death claims, $1 in every 11 is paid on account of death claims from cancer. The actuary of this company estimates that if a boy or girl reaches the age of 10 years, there is more likelihood of his or her dying ultimately from cancer than from tuberculosis or pneumonia. Further, they state that of 100 boys 10 years old the probability is that more than 8 will die of cancer, and of 100 girls 10 years old, more than 11 will eventually succumb to cancer.

The question has been raised more than once whether the increase in the cancer death rate might not be due merely to the aging of the population, because it is well known that the age distribution of our population has been shifting toward a preponderance of older people. While this is an important factor in the situation, it by no means is an answer to the ever-increasing death rate, as this aging does not in any obvious fashion effect the specific death rate among persons of a given age group.

This is the situation which the Essex County Medical Society, as a representative agent of Public Health, faces, and we must consider

what progressive move should be made to protect the health of our citizens.

According to Dr. Burton J. Lee, Director, Memorial Hospital, New York City, cancer patients receive poorer treatment in the hands of physicians and surgeons than any other group of cases in clinical medicine. I do not believe that the medical profession of Essex County can afford to ignore that challenge. It is well and timely for us to consider seriously the wisdom and the necessity of substituting for the present system of general hospitals, with its special departments for the diagnosis and treatment of cancer, a County clinic for this purpose.

While a few of our general hospitals have special departments for the treatment of cancer, they must of necessity be limited in their scope, and some are simply paper institutions; and because there is so much expense involved in the proper installation and maintenance of a cancer clinic, it is really impossible for general hospitals to equip themselves adequately for work in the diagnosis and treatment of cancer.

To meet this demand for a better service for the cancer patient, this County should establish, at the Isolation Hospital, Belleville, a cancer clinic, as an educational project in behalf of the medical profession of the community, where cancerous diseases in all phases may be presented.

It is apparent that no one physician is capable of diagnosing and treating all the forms of malignant tumors that may be encountered in the course of his practice, so that the cancer patient should become the center of a group problem, with the surgeon, the internist, the pathologist, the neurologist, etc., each contributing something of his ability.

Therefore, a properly conducted clinic for the diagnosis and treatment of cancer is the first step in any community toward the better care of the cancer patient.

The functions of such a cancer clinic should be:

(1) The education of the general public so that they may be enlightened as to the value of regular examinations by competent physicians.

(2) To coöperate with these physicians by supplying current information as to the early detection of cancer.

(3) To provide diagnostic, consultation and treatment facilities for cancer.

(4) To establish a follow-up service of patients who may be treated, so that full information may be available to aid research in our efforts to find new methods of combating this disease.

Our Cancer Control Committee, in its desire to find new avenues of disease prevention and to undertake various surveys and research activities, has arranged for a Cancer Progress Exhibition in December, and this should have the active, interested support of every hospital in the County.

I can imagine no gift which would yield this Committee a greater return than the satisfaction of knowing that, as a result of their labors, there would soon be established in this County a clinic devoted to the greatest problem in medicine and one of the greatest hazards to human life, cancer and its allied diseases. This Society should lend its endorsement to the work of its Cancer Committee, and present a set of resolutions requesting our Board of Freeholders to establish a Cancer Clinic at the Isolation Hospital.

Of course these are indeed days of economic stress, with the public demanding lessened expenditures, but I feel confident that the citizens of this County would not accuse our Board of Freeholders of spending their money unwisely in the equipping and maintenance of such a Cancer Clinic, a clinic that will aid greatly in lowering the mortality of this dread disease.

Loyalty to Your Society

In conclusion, let me say that, in my opinion, the Essex County Medical Society has merited the confidence of its members and should be appreciated by all who are interested in organized medicine.

The more of yourself you put into your Society, the more successful will be your Society. Our Society is not governed by any one group, our place of meeting is not too remote or inaccessible; in fact, there is no valid reason why every meeting should not be well attended.

I am forced to say that the attendance of

members from the Oranges, Montclair, Bloomfield, and other suburban districts, has been most unsatisfactory, and I urge every member to come into contact with the establishment which they, by their votes, have set up for the administration of medical affairs in their County.

Each member should accept his responsibility to his Society and coöperate by his attendance and by free exchange of ideas and opinions; and should in every way support the President and other officers in their efforts to promote the welfare of his Society.

THE DIAGNOSIS AND TREATMENT OF INTRACRANIAL INJURIES*

R. Pietri, M.D.,
Asbury Park, N. J.

In recent years there have been many articles written about brain injuries, yet the average general surgeon who very frequently treats these cases, has not fully grasped the few essential points in diagnosis and treatment. Only too frequently cases are classified as to whether they have fracture of the skull, or not, notwithstanding the fact that severe injury to the brain may occur without fracture and extensive linear fractures may be present without evident brain damage. With the exception of depressed fractures of the vault, and those opening into external cavities, fractures of the skull have no importance, *per se,* except in so far as they are evidence of the severity of the impact. I will, therefore, limit my remarks to the actual brain injury and refer to the skull fracture only where it may directly impair the integrity, or eventually through infections, affect the intracranial contents.

In attempting to discuss intracranial injuries, according to the underlying pathologic condition, we must always bear in mind the fact that there is frequently more than one condition present. The classification that follows represents lesions that can be diagnosed clinically and if borne in mind, more intelligently treated.

(1) Concussion.
(2) Acute cerebral œdema.
(3) Miliary punctate hemorrhages.
(4) Contusions.
(5) Lacerations.
(6) Gross hemorrhage into the brain.
(7) Intraventricular hemorrhage.
(8) Subarachnoid hemorrhage.
(9) Epidural hemorrhage.

In the classification of brain injuries, the first type that comes to mind is *concussion.* This word has been made to cover a wide range of possibilities. For example, an individual who has been momentarily unconscious and thereafter, somewhat dazed for a short while, without persistent headache or other symptoms, without evidence of increased intracranial pressure as shown by the spinal mercury manometer and without the slightest deviation from a normal neurological status, is so classified together with the patient who has or has not been unconscious for a longer period of time, but who complains of headaches and dizziness, both persistent, who has a definite elevation in intracranial pressure, though with a clear fluid, and later upon performing encephalography, shows a dilated ventricular system and extensive cortical atrophy, the result of severe œdema, or of minute perivascular hemorrhages and subsequent brain atrophy. Evidently, these 2 cases should not receive the same classification: in the first, there has been only momentary interruption of brain function, in the second, actual brain damage has occurred. Why not limit the word concussion to the first type of case and classify the others according to the underlying pathological condition, i.e., acute brain œdema, or miliary (punctate) hemorrhages? If we accept concussion as represented by the first illustration it requires no further discussion. A short period of rest will be sufficient, after a possible diagnostic lumbar puncture.

Acute uncomplicated cerebral œdema may vary in intensity from a mild increase in intracranial pressure, easily taken care of by repeated lumbar punctures and dehydration measures, to such severe hypertension as to

*(Read at the April 1933 meeting of the Monmouth County Medical Society.)

require operative intervention. The mild type of œdema will present few symptoms; an original period of unconsciousness (which may be absent) followed by drowsiness in varying degree, headache and dizziness, no positive neurological signs and a slight or moderate increase in intracranial pressure, as shown by lumbar puncture. These cases respond rapidly to repeated spinal drainage and dehydration. The former should be performed as often as indicated (every 6-24 hr.) but the pressure should never be allowed to drop below one-half the original. In cases where the pressure drops rapidly after the withdrawal of a small amount (5-10 c.c.) of fluid and within a few hours has again returned to the initial reading, intravenous injections of 50% glucose (50-100 c.c.) are indicated as these are better able to control the intracellular type of œdema, which is more apt to be present. Saturated magnesium sulphate solution, by mouth or rectum, 2 to 4 ounces every 12 to 24 hours, will serve the same purpose, though not as rapidly. Limitation of fluids to 1000 c.c. or even 500 c.c. daily, is an important part of the treatment, as well as elevation of the head and general care and careful observation.

The severe type of cerebral œdema may show stupor or unconsciousness, lasting from a few hours to several days, severe headache, vomiting, high intracranial pressure, and a slow pulse, once the initial shock has passed. Neurological findings are scanty, if any, and vary from time to time, but the eyegrounds ordinarily show blurring of the discs.

In case of initial shock, this condition should be treated first and all examinations postponed until it has been overcome; morphine should be avoided, as it clouds the symptoms and contracts the pupils. It should also be avoided later to control restlessness, as it tends to increase intracranial pressure; but, if absolutely necessary, it can be used in conjunction with caffeine citrate (0.50) as the latter drug has the opposite effect. Instead of morphine, to control restlessness or violence, chloral by rectum, or sodium amytal or luminal by intramuscular injection, may be tried. Most patients will respond to the treatment outlined in the preceding paragraph, i. e., repeated taps and dehydration, but, when the patient fails to respond to these measures, unconsciousness persists and/or the pulse curve continues to go down, irrespective of the blood pressure, then it is time for surgical intervention. Subtemporal decompression then may not only be effective in warding off an impending medullary œdema, but may serve to prevent permanent brain damage. For every case that sustains a high pressure for many days, in spite of non-operative measures, though this pressure be eventually controlled by those same measures, will always result in a damaged individual. These patients, luckily a small percentage, should have the benefit of an early decompression. Patients with medullary œdema, a small rapid pulse, shallow, rapid or stertorous breathing, low blood pressure and high temperature, should not be operated upon for they cannot be helped by any therapeutic procedure.

Miliary punctate perivascular hemorrhage may occur with or without fracture of the skull. Cassasa was probably the first to call attention to their occurrence in fatal cases of so-called concussion without fracture. Of all intracranial injuries, this is probably the most difficult to diagnose during the acute early stages, for it is frequently accompanied by cerebral œdema or subarachnoid hemorrhage, or both. There is no doubt that many cases of head injury that later present the post-traumatic syndrome of Parkinsonism, and which show by encephalography, a symmetrical dilatation of the ventricles and enlarged cortical pathways, are the result of multiple punctate hemorrhage and brain destruction. In 1929 Martland and Beling reported nine fatal cases without fracture and also stated that a large number of the above described post-traumatic cases are also the result of this pathological entity. The symptoms and signs are essentially those of cerebral œdema of the severe type. The treatment of this condition naturally cannot be directed at the lesion itself but as there are usually other factors complicating the picture, such as œdema, these should be treated.

Contusion of the brain represents a more marked extravasation of blood, with actual

brain destruction in one or more localized areas of the brain, frequently on the cortex at the site of the injury and by contrecoup on the opposite side. It is usually accompanied by cerebral œdema and if occurring in one of the silent areas of the brain, its presence may be ignored. As a rule, the temperature is slightly elevated, though not as much as in laceration, and the patient is unconscious and irrational for a longer period of time, than in uncomplicated œdema. If occurring in the motor areas, it will usually affect only one portion, e. g., the face or leg, in contradistinction to extradural hemorrhage which frequently involves the entire side.

In those cases in which contusion in the motor areas occurs without increase in intracranial pressure, the latter fact further serves to differentiate it from the extradural hemorrhage, which is always accompanied by increased tension. The signs obtained on neurological examination, will of course, depend upon the site of the contusion. Treatment depends entirely on the accompanying cerebral œdema, or other complications; for the contusion itself rest and general care should be required; nothing else can be done. Encephalograms performed in these cases, several months after the injury, will reveal a dislocated ventricular system, with a dilated ventricle at the site of the contusion; it is drawn to the same side, as a result of brain atrophy and scar formation.

Laceration of the brain may occur with or without fracture of the skull, and is always present in depressed fractures where the dura has been torn. The patient is usually unconscious and violent while the temperature quickly rises to 103 or 104°. The pulse varies with the degree of cerebral œdema though it may never become slow, because these cases frequently end fatally within 24-48 hours, and pass from the initial state of shock into terminal medullary œdema. Lumbar puncture always reveals a bloody fluid which is frequently under normal pressure, due to the same factors which keep the pulse rate normal or high. Localizing signs are not common, except when the lesion occurs at or near the motor areas, in which case paralysis or motor phenomena, in the form of Jacksonian convulsions will be present. Recently, Gurdjian and Schlafer have pointed out the fact, that in lacerations of the orbital surface of the frontal lobes, paralysis or twitching of the face on the opposite side, is a common occurrence, when the laceration extends postero-laterally to involve the lower extremity of the motor cortex.

As in contusion, treatment depends entirely on whatever complicating factors exist. If there are signs of increased intracranial pressure, treat as in œdema. The latter is usually of intracellular type and therefore, hypertonic intravenous glucose may be more valuable than repeated lumbar punctures. This is also the case in contusion. Of course, lumbar punctures carefully performed, will always help and may be necessary to clear the subarachnoid spaces of free blood. If there is an overlying depressed fracture of the skull operation should be performed immediately after the shock has been controlled. All macerated brain tissue and blood clots should be removed and the dura closed tightly without drainage, unless there is a compound fracture and then rubber drains should be left in. In operating for depressed fractures with laceration, it is occasionally wise to perform subtemporal decompression at the same time, so as to take care of subsequent brain œdema.

Gross hemorrhage into the brain itself is an uncommon lesion in head injuries. It is frequently fatal and rarely diagnosed ante mortem. Treatment differs in no way from that of contusion, except that if diagnosed and properly localized, operation may be attempted 2-3 weeks later for the evacuation of the secondary hemorrhagic cyst.

Intraventricular hemorrhage follows laceration of the wall of the ventricle with frequent involvement of the choroid plexus. These cases will have high temperature from the onset and are rapidly fatal.

Subarachnoid hemorrhage is very often the result of a tear in one or more of the superior cerebral veins which empty into the superior longitudinal sinus. It always accompanies laceration and frequently accompanies contusion. It presents no special symptomatology except when profuse at the base; then signs of meningeal irritation are evident. Bagley

has very clearly demonstrated in young puppies, pathological changes in the central nervous system caused by blood in the subarachnoid space. Diagnosis will be made definite by lumbar puncture. The latter will usually also show high pressure, due either to brain œdema or to meningeal irritation. In mild cases subarachnoid hemorrhage requires no treatment in itself, while moderate extravasation can usually be taken care of by repeated spinal punctures. Severe subarachnoid hemorrhage also may be combated in this manner, but it has been my experience that a more rapid recovery and fewer complications will follow an early decompression with drainage. Many of these head cases with 50% or more blood in the cerebro-spinal fluid, if treated conservatively, often develop cranial nerve palsies or late severe meningeal irritation with very high cell count. I have always used the subtemporal route but was lately impressed by a paper by Francois Ody; he reports 2 cases of severe subarachnoid hemorrhage with signs of bulbar compression, treated successfully by atlanto-occipital drainage. He removes the posterior arch of the atlas and through a large opening in the dura, is able to extract the clots which cause blockage and prevent adequate spinal drainage. The amount of bloody fluid obtained in 24 hours will be as high as 1½ liters during the first 2 or 3 days. He stresses the fact that diagnosis of suitable cases for this operation is very difficult, but points to beginning papilledema and corneal areflexia as helpful signs. Subarachnoid hemorrhage occurring as the result of a tear in the dura in fractures of the base, frequently is accompanied by free drainage through the ear and requires few, if any, spinal punctures. It is well to bear in mind that the auditory canal should not be irrigated but should be kept clean with sterile swabs used 3 to four times a day.

The final type of lesion to be discussed in this attempt at a pathological classification, is *the epidural hemorrhage*. Usually occurring from a tear in the middle meningeal artery, it presents a more or less clear-cut symptomatology as a result of pressure on the motor cortex and on the third cranial nerve. Fracture of the temporal bone is frequently present, but not necessarily so. The characteristic history is as follows: an initial short period of unconsciousness (which may be absent entirely) followed by a longer period during which the patient is mentally clear and then gradually oncoming drowsiness which deepens into coma. Neurological examination will reveal signs of high intracranial pressure caused by increased volume and œdema and motor signs on the opposite side with homolateral oculomotor nerve involvement. Paralysis is often more apparent in the face and arm, for the blood tends to gravitate to the base. Jacksonian convulsions may occur once or repeatedly as well as twitchings of the face or extremities. One sign of great diagnostic significance, though not infallible, is the presence of a dilated pupil on the side of the lesion. It probably represents the first stage of paralysis of the oculomotor nerve caused by the blood clot as it burrows around the base of the brain. Ptosis of the same upper lid may also be present and total oculomotor paralysis may be observed occasionally, when the patient recovers consciousness after operation. Treatment of course, is surgical; removal of the clot and control of the bleeding point is essential to complete recovery. Large bone flaps, though advocated by some neurosurgeons, are in my opinion, unnecessary as the classical Cushing subtemporal decompression will be found sufficient and the patient will have been subjected to much less additional trauma. Lumbar puncture, if attempted, should not be used for reducing pressure.

In conclusion, I wish to state that a large majority (over 85%) of brain injuries can be and should be treated by palliative measures, including lumber punctures and dehydration. Operation must be resorted to in the remaining small percentage of cases. The indications for surgical intervention, in my opinion, include the following:

(1) Depressed fracture of the skull.

(2) Extradural hemorrhage.

(3) Fractures of the skull opening into the frontal sinuses, with a tear in the dura. The reason is clear—possibility of meningitis; according to Eagleton, this occurs in 25% of all such cases.

(4) Severe cerebral œdema uncontrollable by dehydration and lumbar punctures.

(5) Severe subarachnoid hemorrhage.

The first 4 are generally accepted indications, the fifth is commonly ignored in the papers on the subject.

Finally, and so as not to give the impression that I have undervalued roentgen-ray examination, I insist that an x-ray picture be taken as soon as possible, in every case of suspected head injury, for it is extremely useful in the diagnosis of 3 of the conditions which require surgical treatment.

CAUSES OF ERROR IN THE EVALUATION OF DISABILITY FOLLOWING HEAD INJURY

Nathan Zvaifler, M.D., F.A.C.S., F.A.C.O.,
Newark, N. J.

"Penny wise and pound foolish" can well be applied to a system permitting litigation which might have been obviated by competent head examination on all workers unduly exposed to eye or head injury.

Considering the incidence of congenital and acquired disease of the eye, the variations in hearing in both ears, and the deflections of the septum that occur in the average adult worker in the absence of injury, it is amazing that there are not more cases coming to the courts with these defects as a basis for the claim. Very often these preëxisting defects are entirely unknown to the patient, and an injury, no matter how mild, directs his attention to the part; he naturally infers that all his complaints are due to the accident. The Court must accept this, especially in the face of honest medical opinion which finds that an injury could cause the complaints and physical signs.

Another cause of error arises from the fact that, at the time of injury, most of the patients are seen by the general practitioner. His ability to treat the injury and effect a recovery from the acute symptoms is unquestioned; but he is often not able to discover those defects that fall within the province of the specialist, and when, finally—often after months have passed—the specialist does examine the patient, the former is ethically compelled to give to the patient the benefit of any doubt as to the real cause of his findings.

Among the conditions controversially caused by both injury and disease are the following (each of these is from my personal experience):

Eye

Scars on the cornea.

Inflammation of the cornea.

Scars in the sclera.

Iritis and iridocyclitis.

Tumors of the iris and ciliary body.

Differences in the size and reaction of the pupils. (This condition is found not infrequently in normal persons, but is invariably cited to prove or increase the gravity of a head injury.)

Nystagmus. (This, too, is often blamed on trauma, although it is found commonly in otherwise normal individuals.)

Congenital and acquired opacities of the lens.

Congenital absence of, or dislocation of, the lens.

Old foreign bodies in the eye.

Retinitis.

Detachment of the retina.

Variations in the distinctness of the optic disc due to refractive errors, hypertension, sinus disease, etc. If the patient has had a head injury, these variations are invariably given great significance.

Paralysis or weakness of the eye muscles, or derangement of associated eye movements. Differentiation in these cases is often very difficult.

Defects in the visual fields. These demand meticulous care; repeated examination will show some extreme variation in the inattentive, uncoöperative, or antagonistic patient.

Nose

In the nose, the principal controversial finding is the septum which is deflected or thickened. Since the majority of normal people have some deflection of the septum, and since an injury can cause a thickening or a deviation, a dilemma often arises.

Ear

In the ear we are most often confronted with:

Chronic suppurative otitis media.

Healed perforations of the drum.

Diminished hearing on one or both sides. This is very common in otosclerosis and in catarrhal deafness. Whereas the diagnosis in office and clinic practice is fairly simple by means of tuning fork tests and examination of the drums, our examinations performed on patients whose cases are in litigation often give very bizarre results.

Spasms of the muscles about the eustachian orifice.

Mastoiditis, labyrinthitis, and meningitis. Any of these conditions arising within 2 or 3 months of an accident introduces the problem of determining the relationship between the injury and previously existing disease.

Neurological

The commoner nervous diseases with an organic background, such as syphilis, multiple sclerosis, syringomyelia, tics, and cerebral arteriosclerosis, though playing a less important rôle, do often lead to erroneous conclusions as to the cause.

In this discussion it is well to emphasize that an aggravation of a preëxisting condition is compensable, when an injury is proved, and symptoms dating from that time are shown. It would be highly satisfactory if an accurate record of the preëxisting condition were available. Such a record would practically eliminate the expensive expert opinions which differ, not so much—as a rule—about the findings, but rather in their speculation as to the possibility of trauma simulating disease.

We have only to examine statistics to note what a very small proportion of the defects I have enumerated are caused by accident; but even if the incidence be less than 1%, it is usually that one-hundredth case which becomes the case of record. It soon appears that all cases of lead poisoning are accompanied by blurred disc, that every hearing defect is caused by an accident, that every detached retina is the result of trauma, that every case of nystagmus or anisocoria is due to injury. Of course, this is definitely not so.

It is not difficult to show that the abuse exists, and that the remedy is not worse than the disease. Many workers are now being supervised by store and plant physicians. These doctors should be instructed to select those cases showing marked variation from normal and to send them for a special examination. Even a nurse can tell whether a man with glasses has 20/20 vision. (It is important to examine each eye separately.) An employee who continually has cotton in one or both ears, or who is manifestly hard of hearing, is a potential litigation case. Workers exposed to lead or other poisons showing a predilection for eye complications should receive a complete fundus examination. The cost of this work, especially when performed on large groups of workers, should be very moderate. The procedure would not only effect a great saving for the employer, but would help the worker who is essentially honest and honorable and who is anxious to be as nearly a normal, healthy person as possible. These records, of course, would reduce the number of compensation claims filed. Under these circumstances, the determination by the judge of the extent of disability, if any, in conditions that might be caused by either injury or disease, would be easier and more equitable.

Conclusions

(1) Preëxisting organic defects are often differentiated from the effects of recent trauma only with great difficulty.

(2) The worker may be entirely unaware of any previous condition until an accident draws his attention to the part.

(3) Early examination (or, preferably, treatment) by the consultant for injuries lying within the specialist's province would, in the long run, be cheaper.

(4) Preëmployment, special head examinations should be made to protect the worker from increased liability to accident aggravated or induced by congenital or acquired disease. This would also protect the employer, for it would furnish him with a complete record, available to disprove a claim for compensation based on previous injury or disease.

DEAFNESS IN CHILDHOOD

Edward A. Atwood, M.D.,
Paterson, N. J.

The appreciation of the significance of the effects of impaired hearing in childhood in their relations to the educational, economic and social structure of modern civilization is becoming more and more apparent.

To verify this statement, it is necessary only to reflect a moment on the present trend of thought, which has induced the great consideration given this problem by special interested groups composed of otologists, school and health authorities, industrial leaders and leagues for the hard of hearing. These have been mobilized in every section of the country in ever-increasing numbers, giving time, energy and thought to the intensive study of childhood deafness from the standpoint of prevention, diagnosis, treatment and education.

It redounds to the credit of the medical profession and to those organizations and societies associated with them in the pursuit of these studies, that they are conducting a tremendous amount of investigation and scientific research in order to avail themselves of knowledge enabling them to impart the information necessary to become the mediator between the progress of this crippling condition—the cause of so much mental suffering, economic loss and social expulsion—and the afflicted patient.

The results to be achieved from these investigations and the knowledge gained thereby provide for our use a 3-point program and duty: prevention, diagnosis, and education.

The component parts of this program are dependent on each other, for, only when they are considered together can the great benefits derived from their consideration and practice be realized. Preventive medicine nowhere plays a greater part with promise of more success than in the field of preventable deafness.

In order that the greatest progress may be made, it logically follows that prevention must begin in infancy and childhood. A hearing defect in a child must be considered a crippling disease, and the problem viewed not only from the physical standpoint but from the psychic as well. Only a moment will be sufficient to convince us that the problem of impaired hearing in the adult who has acquired the defect, after developmental and educational processes have been completed, is a far different matter than the same defect in a young child who is commencing this training handicapped by a loss of the sense of hearing. This loss prevents the child from receiving at the most impressionable and important period in life, when mental, social and psychological processes are plastic, the moulding influence of education; and by education I mean not only instruction in school, but education in the broad sense of the word implying that mental culture which is gained from social intercourse.

Lack of this influence is the reason the deafened child becomes inattentive, seclusive, and delinquent in his studies and social activities. He later develops morbid and introspective ideas, so that without help he abandons the effort to adjust to his changed environment and resigns himself to a condition of social dissociation. By recent surveys and subsequent follow-ups, it was frequently noted that many children considered backward by their teachers and parents, were found, instead, to be hard of hearing. With proper methods of instruction adapted to their auditory needs, they progressed as rapidly as their classmates.

The prevention of deafness offers a broad field for a real and constructive social service. Much can be accomplished by the early and vigorous treatment of most ear defects, but when deafness is once established, there are distinct limitations to the possibilities of our methods of treatment, with the resultant effects of educational and economic loss, social hardships, and changed psychological reactions.

Based on statistics from investigators in all sections of the country, some startling results have been published, which, in the light of our much vaunted modern civilization shock our sense of complacency when the significance of these results is recognized and considered.

In order to make an accurate analysis of the existing conditions, hearing surveys have been conducted during the past several years in all parts of the country. Investigators, working

separately or with school authorities, social agencies and leagues-for-the-hard-of-hearing, have made these studies and drawn conclusions from their work. This has given a cross-section picture of the incidence, etiology and diagnosis enabling us to use these facts as a basis for preventive and therapeutic measures, both medical and educational.

These surveys have been made possible by the advent of the 4-A audiometer by means of which a large number of school children (in groups of 40 at a time) can be examined in a relatively brief period; repeated check-ups and re-examinations can be made at stated intervals in order to determine the amount of progress, value of home follow-up and treatment, together with the advice needed to re-arrange the educational requirements for those who show a hearing loss.

Reports from these various sources show that over 10% of our school children have a physical defect of hearing. This figure is in accord with the result of the Rodin survey carried out on the West Coast, in which 36,191 school children in 118 schools in San Francisco ranging from 9 to 16 years of age were examined. Three thousand four hundred and twenty-seven, or 9.5%, showed a hearing loss of 9 or more sensation units in one or both ears. Of this number, 441 children, or 1½%, had sufficient loss of hearing to be referred for instruction in lip reading.

A similar survey of a group of 9741 children at Albany, reported by Freund, gave a total of 757 with impaired hearing, and the incidence as determined by Fowler and Fletcher in their large survey showed 14.4% with like hearing defects.

On the same basis with 24,000,000 school children in the United States there are over 3,000,000 with some defect of hearing, 340,000 of whom have sufficient impairment to require instruction in lip reading.

These are our future citizens; taken from every part of the country, a very definite number of them have defects in aural acuity wholly unsuspected by their parents or teachers. These startling facts should stimulate all of us who are interested in the study of this vital subject to greater efforts in the recognition and prevention of this condition in order that we may lower this percentage by every means within our power. It has been conservatively estimated that preventable deafness could be reduced 25% by the employment of a broad program of diagnosis and treatment.

The practice of prevention of deafness embodies 2 factors: (1) Early detection and diagnosis, and (2) early treatment at a time when therapeutic measures may be applied to eradicate the cause before hearing function is imperiled.

This problem cannot properly be attacked at the source if the physician or otologist considers only the patients who consult him in private practice or at the clinic, many of whom are adults who have postponed treatment or advice until only little can be accomplished for the restoration of destroyed function. The great need of discovering hearing defects in early childhood cannot be over-emphasized. Many hearing defects at this age are of a minor nature readily corrected by treatment, and if recognized before permanent changes have taken place much can be done to reduce the large number of cases of permanent acquired deafness in later life.

Secondly, it is necessary to invoke the aid of all the agencies, medical, research, health, educational and industrial, in order that they may ally themselves in this movement and cooperate in the diagnostic and therapeutic measures for the detection and cure of deafness in its earliest stages.

The etiological factors to be considered are many and varied and assume an important part in the consideration of both the treatment and prevention of deafness. Scarlet fever and measles contribute the greatest number of cases in the early years up to the age of 10. Deafness resulting from these diseases may be caused not only by a severe otitis media, but also, frequently, by a toxic neuritis of the eighth nerve without an accompanying middle-ear infection. Berberich, quoting the Vienna statistics of Hofman, states that acute otitis media is the more common complication of pneumonia in early childhood up to 4 years of age, occurring once in every 3 cases. Shambaugh et al. in listing the etiology of 3120 cases of deafness in school children found 209

followed acute cerebrospinal meningitis, 100 scarlet fever, 97 measles, 91 influenza, 66 mastoidectomies following acute otitis media, 37 poliomyelitis; lues was the probable cause in 24, parotitis in 12, and otosclerosis in 6.

The outline of treatment falls naturally into 2 broad groups: (1) medical, (2) educational and rehabilitative.

Deafness in the school child is definitely related to the types of medical care received in the first 10 years of life. According to Taylor, in communities where the cost of medical care is not an economic factor only 2% of deafness is found, where conditions are only fair, 15%, and in the poorest environments, 25%.

Inflammatory or obstructive conditions in the nose and throat, or infections in the sinuses, teeth or more distant parts of the body should claim the attention of the physician. Proper attention to the acute inflammations of the nose and throat during the course of the exanthemata or other infectious childhood diseases in order to prevent as far as possible infection of the middle-ear is necessary; prompt and proper management of the ear infection when it occurs in order to minimize the amount of subsequent damage should receive the most careful consideration. Chronic suppurations of the ear should never be neglected, for during each passing week or month that an ear discharges, a greater amount of necrosis and consequent destruction of hearing occurs. In this respect, it is encouraging to note that certain operations for the cure of the discharge, which are, in themselves, destructive to hearing, are becoming less and less frequent, while more attention is being paid to the conservative methods of treatment in order to heal the chronic otitis.

Dr. Fowler has pointed out the way by which the diagnostic, therapeutic and educational methods may be correlated and utilized for the aid of the deafened. Careful clinical and laboratory investigations are carried out in his specially established clinic, at the Manhattan Eye and Ear Hospital, for the children found afflicted in the school survey by the New York League for the Hard of Hearing. Personal and family history, clinical examination of the ear, nose and throat and sinuses, together with labyrinth tests and functional tests of hearing with forks and audiometer form the basis of the examination and treatment. The clinical and x-ray laboratories are used for routine Wassermanns, mastoid and sinus x-rays, tuberculin tests and urinalyses. All of these entail a tremendous amount of time and effort but later will prove to be of inestimable value as a scientific approach to the solution of this problem.

Finally, we must consider the institution of an educational program for the rehabilitation of those who are deafened so that they may once more enjoy the satisfaction of social fellowship, be led out of seclusion, divested of anti-social characteristics and conducted into an environment free from mental suffering.

The greatest aid to rehabilitation, placing those afflicted with deafness on a plane equal in educational and social advantage to those not so afflicted, as well as the most powerful weapon against seclusion is the art of lip reading which today is being taught in 44 of our city school systems, and in 60 cities which are giving evening instructions in this important help at practically no charge.

The slogan of the League for the Hard of Hearing, "Lip reading is a great help for the deafened", should find a conspicuous place in every physician's office, in order that the public may be brought to realize the importance of this great aid to the restoration of the deafened patient to a normal status. It should be stressed, however, that here, as with treatment, (1) the most successful results in the learning of lip reading are attained while the hearing is not too greatly impaired and (2) the practice of this great aid should be taken for what it is, using the eyes to aid the ears, rather than as a last resort.

In conclusion, one fact stands out clearly, and that is, if this incidence is to be reduced and if countless numbers of children are to be spared the crippling effects of deafness, all the agencies for the study of prevention and cure of this defect must be put into action at once, and their scope increased. A few courageous pioneering investigators scattered throughout the country with a vision of achievement have pointed the way, but their missionary efforts must be augmented by the

coöperation of every interested person, scientific worker or social agency. Only when all of these agencies function as a harmonious unit, giving their combined efforts to a common cause, to disseminate knowledge, increase educational facilities and indicate the way to the successful solution of this problem, will the results obtained be commensurate with our ideals in freeing childhood from this great educational, physiological and social handicap.

CARCINOMA OF THE TONSIL, WITH CASE REPORT

J. Berkeley Gordon, M.D.,
Medical Director of the New Jersey State Hospital,
Marlboro, N. J.

Malignant disease of the tonsil occurs in the form of carcinoma and sarcoma. Carcinoma is distinctly more frequent and offers a better prognosis than the rarer sarcoma. Sarcoma occurs at an earlier age and is usually confined to the tissues of the tonsil itself, although it may spread into the substance of the soft palate. It presents itself as a smooth globular swelling covered with a greyish mucosa. On palpation it is firm in consistency but never as hard as carcinoma. Ulceration and enlargement of the submaxillary and cervical glands are late phenomena. Sarcoma must be differentiated from hypertrophy of the tonsil, from gumma, and from quinsy.

In a report of 387 cases of cancer of the tongue, cheek, jaws, palate and tonsils treated at Collis P. Huntington Memorial Hospital and at Masachusetts General Hospital during 1921-22 and 23, Simmons makes the following observations:

Etiology: 90.7% were males; 9.3% were females. The average age was 59 years, but 82% in the series were over 50. There were 2 under 30, and the youngest was 18. Dintenfass in commenting on the age distribution of tonsillar malignancies remarks that the age of the patient should not be relied upon to substantiate the diagnosis, inasmuch as cases have been reported as early as 18 months and as late as 80 years. In Simmons' series, 80% used tobacco in some form; most of them smoked, some both smoked and chewed. Leukoplakia was present in 25% and is to be regarded as a distinct pre-cancerous lesion. When present, leukoplakia was associated with syphilis 70% of the time; and the blood Wassermann reaction was positive in 20% of the cases in which it was examined. It is established that ill-fitting dentures and diseased teeth are definite etiological agents.

In Simmons' group the individuals were followed for not less than 5 years and the results of treatment for the years 1921-23 were similar to those of the preceding 3 years, though the results of irradiation were somewhat better due to improved technic. In primary cases without clinical evidence of metastasis, surgical treatment offers 40% chance of 5-year cure as against 8½% by radiation therapy. Postoperative prophylactic x-ray had no effect in preventing recurrence; and life expectation is longer following surgical, than radiation therapy.

Malignancy in the tonsil is primary in a great majority of instances. Ballenger and other writers of a decade ago thought that carcinoma of the tonsil was nearly always secondary to carcinoma of the tongue or faucial pillars. This belief has been refuted by present-day observers. Schlemmer, in experimental studies with dyes, and Richard Waldapfel of the Viennese Clinic have shown that the tonsils are efferent and not afferent organs, and that because of the direction of the flow of lymph it would be impossible for tonsillar affections to originate from environmental tissue.

The site of the neoplasm on the tonsil is of interest. Ross has pointed out that whenever epithelium normally or abnormally tends to change its type, such a change is more likely to produce epithelioma on the periphery than in the center of an epithelial area. This is demonstrated in carcinoma of the lips and anus, where the malignancy seems to have a predilection for the mucocutaneous junction. The same factor applies to the tonsil where the favorite site of the malignancy is at the junction of the epithelial surface of the tonsil and its pillar. This was the point of origin of the tonsillar malignancy here reported. This

is in contradiction to Cohnheim's idea that carcinoma of the tonsil is due to tucking-in of epithelium with gradual shutting off of the enclosed cells.

As already mentioned, lues is an important factor in tonsillar malignancies. It is to be remembered that malignancy and syphilis may be present simultaneously. Gummatous areas have long been known to act as predecessors of neoplasm. A negative Wassermann is, therefore, an important finding. In supposedly luetic cases, unless there is an immediate response to arsphenamine and other antiluetic therapy, malignancy should be suspected and investigated.

An interesting case in which syphilis, carcinoma of the tonsil, and cancer of the stomach in the form of plastic linitis co-existed was reported by Moncany and Cornil in 1925. The glands in the cervical region were not invaded to a great extent nor were those of the mediastinum, but there was a chain of large glands on the lesser curvature of the stomach. Histologic examination of the gastric tumor showed that it was an atypical epithelioma having the appearance of plastic linitis with cellular nodules penetrating through the muscle layers. Examination of the tonsillar tumor showed that it was a cancer formed by rounded irregular or elongated masses included in a very loose meshwork which was formed of rather dense connective tissue. Under low magnification the tumor gave the impression of a lymphocytoma, but it was found that the tumor originated at the level of the malpighian epithelium at 1 or 2 points. In certain places there were epithelial pearls.

Hence, in this case there was an undifferentiated malpighian epithelioma of the tonsil coexistent with plastic linitis of the stomach. It is possible that the atypical epithelioma of the stomach might have been secondary to the malpighian cancer of the tonsil, but the authors are inclined to consider that both neoplasms were simultaneous.



Throat tumor 80X

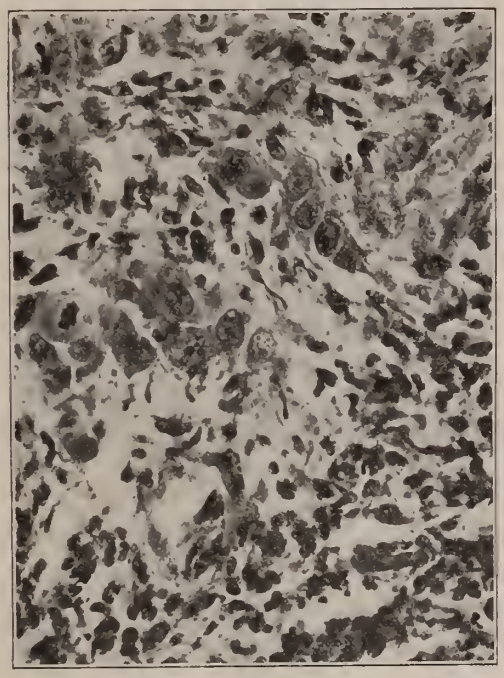


Throat tumor 160X

Symptoms. This form of cancer is not painful in its early stages and will probably not be diagnosed promptly unless found by some observer in coincidental examination of the mouth and throat. The warnings of pain, hemorrhage and lymphadenopathy are likely to

appear only after the process is so far advanced as to cause the victim to seek medical advice after hope for complete extirpation is gone. Pain usually starts as a dull heavy sensation, easily tolerated while at rest, but becoming very sharp, with radiation to the ears during mastication and seriously interfering with deglutition. In some cases there are severe attacks of hemicrania.

Ashhurst reported a case of carcinoma of the right tonsil in a man of 61. The tonsil was removed through the mouth, and 6 days later a dissection of the cervical lymphatics



Throat tumor 480X

was done. In this procedure, the right common carotid artery was occluded by a clamp for 1 hour. The internal carotid artery and internal jugular vein were left intact but the external carotid was excised with the tumor mass. There was a complete left-sided hemiplegia on the following morning. The patient became mentally disturbed and died 3 weeks later, of cerebral thrombosis.

Malignant tumors of the pharynx and larynx are discussed by A. Zuppinger (Zurich). Of 280 cases, 23 were in the larynx and 257 in the pharynx. Of the entire number of growths only 20 were sarcomas and in the entire series only 68 were operable, though in half no metastases were found. Operation was performed when possible and in a few cases it was combined with radiotherapy. Of the whole 280, 11 (including 5 sarcomas) lived 1 to 9 years, 3 subjects died from intercurrent disease without recurrence. The best results occurred in the cases of cancer of the interior of the larynx; 4 of these 8 individuals became symptom-free.

According to New, Broders and Childrey, in 14 years there have been 1393 subjects with malignant growth in the pharynx and base of the tongue at the Mayo Clinic and they review 624 examined microscopically. The most common are lymphosarcomas and epitheliomas graded 3 and 4; 84.2% were in males and the average age in the series was 52.1 years—a few were under 20. Of all patients, 24.7% noted enlarged cervical nodes as the first symptom. A great variety of surgical and non-surgical treatment had been given in almost all, without proper diagnosis. Patients were treated at the Clinic by irradiation. Surgical procedures, diathermy or cautery were used with irradiation in selected cases. Lymphosarcoma was treated almost entirely by irradiation; 16.48% of all patients treated were alive for 3 years or more after treatment. The average length of life after treatment was 34.5 months and the untreated cases averaged 6.8 months of life after examination. Palliative treatment had little if any effect in prolonging life. A higher percentage of patients with epithelioma graded 4 are alive than of lymphosarcoma, but the duration after examination is longer in lymphosarcoma. Of those who died 96% died of the malignant process.

Case Report

The case here reported occurred in a patient suffering from an organic psychosis due to lead poisoning. The tumor of the tonsil was discovered in the course of a physcial examination incident to his transfer to a new psychopathic hospital. When the lesion was first observed, the patient was symptomless, but interference with deglutition and pain appeared

shortly. Cervical lymphadenopathy appeared much later, although metastasis to the larynx with aphonia had taken place within 2 weeks after the malignancy was first noted. The trend of the metastasis as demonstrated at autopsy was through the tracheo-bronchial tree into the mediastinum and lungs. Much to our surprise, there was no gross hemorrhage, although the ulceration in the pharynx was considerable. The process completely destroyed both tonsils, the uvula and soft palate, invaded the buccal mucosa, the base of the tongue, the anterior surface of the epiglottis and the interior of the larynx including the vocal folds. The greater cornua of the hyoid bone were exposed and eroded. The nodes of the tracheobronchial system were involved and there was a large carcinomatous mass in the lower lobe of the left lung involving the diaphragmatic pleura. The only other remarkable feature noted at autopsy was an œdema of the pia-arachnoid and brain with distension of the lateral ventricles (the cerebrospinal fluid was under such pressure that it spurted approximately 2 inches when the pia was nicked). There was a congenital absence of the right kidney and ureter, though the right suprarenal gland was normally situated. The left kidney was enlarged, asymmetrical and lobulated at its lower pole. There were dense colonic adhesions with partial obstruction at both the hepatic and splenic flexures.

Histological examination, by 2 independent workers, of biopsy material taken at the time the lesion was discovered, revealed an infiltrative carcinoma of Broder's Type 3.

The work done on the use of colloidal preparations of the heavy metals in the treatment of inoperable malignancies is well known and will merely be alluded to here. What connection, if any, the malignancy in this case had with the lead encephalopathy is problematic. We should, perhaps, expect the lead to act as an inhibiting factor rather than an etiological agent.

A clinical summary of the case follows:

G. C., No. 257, a white male, aged 46, married, born in Hungary. *Family history* irrelevant. Occupation: Laborer in smelteries. He had worked in smelteries and metal refineries for 21 years; at the end of this period he was sent home a victim of lead poisoning involving both central and peripheral nerves, and was awarded a compensation of $17 a week. During his working period, he had been severely burned from head to waist by molten lead. Psychosis was of gradual onset eventuating in his commitment to a mental hospital on September 29, 1930, 3 years after he stopped work.

Physical examination on admission showed a poorly nourished white male, weighing 136 pounds. There were no paralyses; hand grips and lower extremities were weak, gait unsteady with considerable difficulty in balancing, all deep reflexes increased, abdominal and cremasterics absent, no Babinski or ankle clonus was found; fine tremor of tongue and fingers; eye-grounds showed retinal vessels of increased tortuosity. There was severe periodontoclasia. Blood serum Wassermann reaction negative; urinalysis negative.

Mental examination showed nothing conspicuous aside from the confusion and deterioration of an organic brain disease. He gave a fairly clear account of a peripheral neuritis in his forearms and lead colic 3 years previously, for which he had been treated in a general hospital.

On June 17, 1931, shortly after his transfer to another mental hospital, in the course of a general physical examination an extensive ulceration was noted at the junction of the right tonsil and its anterior pillar extending upward onto the soft palate. Smears of the material were examined for acid-fast organisms, with negative results. Biopsy was made and the specimen reported as an infiltrative carcinoma of Broder's Type 3. At the time of biopsy, inspection of the interior of the larynx showed metastasis to the vocal folds. Neither surgery nor irradiation was attempted because of the metastasis and his very poor physical condition. Death occurred February 21, 1932, 8 months after the lesion was recognized. Patient was markedly cachectic, weighing only 77 pounds at the time of death, a loss of 59 pounds from his original weight on admission and a loss of 34 pounds in the 8 months.

SUPRAPUBIC PROSTATECTOMY INCLUDING PREOPERATIVE AND POSTOPERATIVE TREATMENT*

William H. Mackinney, M.D.,
Philadelphia, Pa.

I think we will agree in the statement that the cure of a patient suffering with urinary disability and its attendant constitutional symptoms, provoked by so-called benign prostatic hyperplasia, depends upon our ability to invoke proper surgical treatment, directed toward the removal of the obstructing prostatic tissue.

To the best of my knowledge, there is no medical, manipulative, electrical or other treatment which has a curative effect upon the hypertrophied gland. On the other hand, the diagnosis of prostatism being established, there is no condition of the urinary tract which calls for greater display of medical acumen than does this urologic problem. Let us remember that prostatic obstructions constitute the most frequent and most fatal disease of the urinary tract. In a recent report by MacKenzie and Seng, in the Journal of Urology, of last month, they state from an analysis of about 11,665 admissions, over a period of 15 years, that "Prostatism is the disease entity that shows the greatest number of deaths". The admissions for prostatism were 1638 cases, more than double the number of the next most frequent urologic condition, namely, ureteral calculus (673).

All cases of prostatism are ultimately divided into 2 classes, from the standpoint of treatment. (1) Those in whom no operation to remove the obstruction can be performed with a reasonable degree of safety and reasonable hope of cure. (2) Those to whom we may recommend some surgical procedure directed toward the removal of the obstructing prostatic tissue.

To place a patient in either one of these groups may be a comparatively easy problem, or one which may entail weeks or months of study and treatment. Under no circumstances should a hasty conclusion be reached and operations should never be performed without a most thorough study of the local pathology and its secondary effects, particularly upon the urinary and cardiovascular systems. Let me impress upon you that partial or complete prostatectomies, no matter how performed, are never operative emergencies. There is no excuse for undertaking such operations without adequate preliminary study and treatment. An analysis of the mortality rates of operative procedures in the hands of many general surgeons of acknowledged technical ability, convinces me that in many instances their unusually high mortality rates are due to inadequate preliminary treatment of cases that, in all probability, would, if given sufficient time and adequate preliminary treatment, recover, and the performance of operations upon patients who should not have been operated upon at any time. We will all concede that mistakes in operative judgment occur. The very best apparent risks will occasionally succumb and the poor risk will occasionally make an uneventful recovery; but it is just as certain that the good operative risk will usually get well and the known poor operative risk will generally die, other things being equal.

In the selection of the proper operation to be performed for the relief of prostatic obstruction, it would seem that certain operations are more adapted to a particular type of prostatic obstruction than are others. Based upon the pathology of the prostatic obstruction one would probably conclude: that perhaps uncomplicated enlargements of the median lobe, fibrous bars, and fibrosis of the neck of the bladder might fall naturally into the category of those cases in which the electroresectoscope or punch operations were indicated; that large intravesical enlargements of the lateral and median lobes combined or the lateral lobes alone might be more properly relieved by a suprapubic prostatectomy; and finally, that non-complicated intracapsular enlargements, particularly in the obese patient, would indicate a perineal approach. Now as a matter of fact, the method of surgical approach is, generally speaking, not based entirely upon the pathological indications, but

*(Read before the Atlantic County Medical Society, April 14, 1933.)

upon the personal proclivity of the attending surgeon to perform the operation in which he has become most skilled. As a result, we find that as experience with one type of operation increases in the hands of the operator its field of application increases.

We now find that those especially skilled in the use of the resectoscope and cautery punch operation are finding ever-increasing indications for their use, while those who constantly attack the prostate, suprapubically or perineally, become as firmly rooted in personal selection of these methods.

I think I am correct when I say that, generally speaking, suprapubic prostatectomy is the most frequent operation performed for the permanent relief of prostatic obstruction. I feel sure that it may not always be the best operation as indicated by the pathology, but I am convinced that for many years to come it will occupy a permanent place in prostatic surgery. It is today, practically, the only operation in the hands of general surgeons applied to the relief of prostatic obstruction, and it is, therefore, a subject of general importance.

The preoperative treatment of a prostatic constitutes, in my judgment, the most important part of the management of the case. Irrespective of the ultimate method of relieving the prostatic obstruction, the necessity for careful preoperative treatment remains the same. The first indication to be met is the relief of urinary retention. This, as a rule, may be accomplished by an indwelling catheter. Never empty quickly the bladder subject to chronic distention. It is a fatal mistake. Decompress gradually. Also avoid the use of the cystoscope at this time. When it is impossible to pass a catheter, suprapubic drainage, adapted for gradual decompression, must be substituted. After gradual decompression has been effected, begin continuous drainage or intermittent drainage, govern the amount of fluid ingested by the ability of the kidney to eliminate an almost equal quantity. The practice of attempting to force large quantities of fluid, when the total quantity of urine remains low, is, I think, a mistake. As the quantity of urine increases, the fluid intake may be proportionately increased.

The return of adequate renal function is indicated by a relief of the constitutional symptoms of uremia in its many and varied manifestations and confirmed by chemical examination of the blood for urea and urea nitrogen and an increase of stabilization of the P. S. P. elimination.

While effecting urinary drainage, the bladder should receive adequate treatment to combat the infection by the use of various antiseptics applied by irrigation. I cannot discuss their relative merits but favor permanganate of potash, 1-8000 solution.

The cardiovascular system demands special attention. It is well to have the advice of a competent cardiologist or internist, for in my experience more fatal results are due to myocardial disease than to any other cause. A soft compressible pulse, a persistent increase in rate, weak distant muscle tones and low systolic pressure, all indicate a degenerated myocardium. Digitalis is probably the best of heart stimulants and may improve the circulation to a considerable degree and render operative measures reasonably safe; yet how frequently our operative successes are blasted by untimely cardiac failure, frequently at a time when convalescence is otherwise well advanced. I deem it important during preoperative treatment to allow the patient considerable freedom in activity; to pay due attention to his digestion and elimination, and remove, if possible, the depression of mental worries. The administration of one of the many urinary antiseptics is advisable to aid in combating the usual colon bacillus infection.

It is unnecessary to discuss in detail the complete technic of suprapubic prostatectomy, but there are certain features which for the sake of discussion might properly be considered.

Preliminary bilateral vasectomy is a valuable procedure, as it effectually prevents the development of epididymitis during the entire course of treatment or operation. Theoretically it should precede even catheter drainage, but rarely is it done at this time because of the pressing need of vesical drainage. When operation has been determined upon, it should precede, by a few days, the

cystotomy. A local infiltration anesthesia for this procedure suffices.

A discussion of the anesthesia employed for the cystotomy will probably involve the relative safety of local infiltrative and block anesthesias, gas and ether and spinal anesthesias. There is no question in my mind that spinal anesthesia gives the quickest and most satisfactory relaxation, but that it is the safest, I am sure is not true. In an uncomplicated suprapubic cystotomy I would recommend local infiltration anesthesia with Novocain-Adrenalin Solution as the safest anesthesia for the cystotomy, and the use of nitrous oxide and oxygen for the enucleation of the prostate as far safer for the patient, but less satisfactory to the surgeon.

Much discussion has taken place as to the merits of the so-called stage operations. Personally, I am a firm advocate of the two-stage suprapublic prostatectomy, even in reasonably good operative risks. The dangers of pericystitis are largely avoided. There is less hemorrhage following enucleation, in spite of the fact that the prostate because of shrinkage is more difficult to enucleate. The shock of the divided operation is usually less and we can hardly gainsay the fact that a week or ten days of free suprapubic drainage is of benefit to the patient.

As to the method of enculeation, one of two procedures is usually undertaken. The first involves the splitting of the anterior urethral mucosa by pressure and striking the line of cleavage anteriorly; the other, an incision of the mucous membrane and capsule over the most pronounced part of the intravesical projection of the hypertrophied prostate. Of the two methods, the first is easier, but entails a greater risk of rupturing the engorged veins of the plexus Santorini. I use it, however, in the enucleation stage of a two-stage operation, almost invariably, and believe that the risk of severe hemorrhage is largely avoided by the relief of congestion afforded by the preliminary cystotomy. The support of the prostate by a finger in the rectum aids materially in the enucleation.

The prostatic bed is then carefully palpated for small nodules which sometimes adhere to the capsule—these are removed. The edge of the internal sphincter is inspected for tabs of mucous membrane, which if present should be trimmed off.

As to the control of hemorrhage after enucleation: I believe nothing to be superior to the packing of the prostate bed with gauze, fortified with suture, when necessary, of the margin of the internal sphincter by interrupted suture. The packing can be safely removed on the third or fourth day.

The various types of compression bags are difficult to hold in place and are sometimes unreliable. I have found it necessary at times to remove them and blindly pack the prostatic bed with gauze to control persistent bleeding from the prostatic bed. An application of Zenker's Solution to the prostatic bed after enucleation has been recently recommended by T. Mullin (B. M. J. Nov. 1932) for the control of bleeding. So far I have not tried it.

Upon general surgical principles I am opposed to the primary suture of the prostatic bed around an indwelling catheter and the primary closure of the bladder. I admit I have never done it, and, naturally, should not speak of it, but I feel that it is surgically unwise to close an infected prostatic bed and hope for primary healing.

The immediate postoperative treatment entails a watch for bleeding and the administration of fluid by hypodermoclysis or in certain cases the continuous intravenous drop infusion of normal saline solution. If the stomach is retentive, possibly one to two thousand c.c. of fluid by this method suffices, but when nausea or vomiting occurs, or there are evidences of impending failure of renal function, the above treatment should be repeated or continued so that an adequate amount of fluid is given slowly. Rapid intravenous transfusion is only indicated when the patient has lost a considerable amount of blood at the time of operation. Blood transfusion may also be indicated to meet the emergency.

If spinal anesthesia has been used the foot of the bed should be elevated 8 or 10 inches for about 8 hours. Surgical shock should be combated by external heat and necessary stimulation.

Following the preliminary cystotomy the pre-vesical drainage is removed about the

third day. The bladder receives proper irrigation once or twice daily, depending upon the amount of pus in the bladder. Occasionally, as a result of ammoniacal decomposition, an annoying deposit of phosphatic salts accumulates on the drainage tube and on the wound. These may be combated by irrigation of the wound with very weak hydrochloric or one-half per cent phosphoric acid solution. The urine should be acidulated with ac. phos. of sod. or ammon. chlor. taken internally.

It has been my custom to remove the suprapubic drainage tube about 3 days before the contemplated enucleation. This allows the areas of pressure necrosis surrounding the tube to become healthy granulating tissue. An application of 5% Iodine solution, daily, to the granulating surface promotes healthy granulation. Much has been written concerning the necessity of having the patient get out of bed on the second or third day following operation. I have never been able routinely to carry out this suggestion. I believe the patient should be made to change position in bed frequently after the first day and the body should be elevated by a back-rest or a movable head-mattress, but my patients seem to be quite content to remain in bed for about a week.

Before removing the gauze packing, the bowels should be moved by a mild laxative, such as milk of magnesia and an enema. The presence of the gauze packing effectually prevents the hemorrhage which might follow the use of a laxative and an enema.

In order to facilitate the closure of the suprapubic wound it is advisable to place in the urethra an indwelling catheter. I usually introduce one approximately 3 days after the removal of the prostatic gauze and suprapubic drainage tube. Occasionally, this catheter is poorly tolerated and fever intervenes, making its removal necessary. It also happens occasionally during convalescence that an irregular fever supervenes as a result of an infection of the seminal vesicles. Here a catheter is poorly tolerated and must be removed. Hot rectal irrigations and later gentle massage of the vesicles followed by irrigation of the bladder and urethra, generally cause the infection to subside, but the convalescence is necessarily delayed. It is this complication that would be accompanied by an epididymitis in the absence of preliminary vasectomy.

The catheter drainage is maintained until the bladder wound is closed completely for 3 days and resists leakage during the daily irrigation. Following the removal of the catheter and the restoration of the urinary function it will be found that the urine still contains considerable pus. It is advisable to continue to treat the cystitis until the urine is clear. This may entail several weeks of treatment, but is essential if the full benefits of the operation are to be enjoyed by the patient.

In conclusion, it may be said that a properly performed suprapubic operation in benign hypertrophy and intravesical projection of the lateral and median lobes is on the whole a rather satisfactory operation.

It has been my misfortune to have a larger mortality rate than is reported by many; it has been 10.3% in 126 consecutive operations. The chief causes of death have been attributed to the cardiovascular system including one of pulmonary embolus and one of apoplexy. The remainder died of uremia and systemic infections. In 2 cases a secondary operation by means of the Caulk punch was undertaken for a contracture of the vesical neck, subsequent to prostatectomy, one 8 months and one 2 years after operation. In 5 cases an unsuspected carcinoma was reported by pathological examination.

THE PLIGHT OF THE PROSTATIC*

Clyde W. Collings, M.D.,
New York City

In what sort of predicament is the prostatic sufferer when the residual urine starts to pile up or when the patient acutely develops complete retention? Is the obstructive lesion dangerous to life? What effect does prostatic obstruction have on the rest of the body? What, more than anything else, concerns the patient? He naturally asks, "How may I be relieved?"

*(Read before the Atlantic County Medical Society, April 14, 1933.)

Is it a simple problem without danger, or is it a matter of life and death?

Etiology

Prostatic obstruction develops in 1 of 3 ways: The small, firm, fibrotic prostate, usually the result of a chronic inflammatory process; the benign enlargement in which the glandular structures enlarge; the carcinoma, which usually produces obstruction by infiltrating the floor of the bladder neck.

Symptoms

The symptoms of the several types of prostatic obstruction are very much the same. The patient notices that he has to get up at night to void, the day frequency increases, residual urine accumulates, and infection, accompanied by burning, often occurs. It is unfortunate that neither the patient nor physician realizes that these symptoms are danger signals. At this stage the patient may be relieved before irreparable kidney and cardio-vascular damage has taken place. The sooner the patient consults the urologist, the simpler is the problem, the less the danger to life. Procrastination means weeks of hospitalization and a mortality rate of from 8 to 18%.

Diagnosis

By rectal palpation, a fibrous prostate seems small, firm and irregular; a benign enlargement feels moderately or markedly enlarged, bulging into the rectal lumen, smooth and elastic; a carcinoma feels stony hard and fixed, infiltrating to the pelvic wall, to the base of the bladder, or to the seminal vesicular regions. By cystourethroscopic examination, the prostatic bar is seen obstructing the floor of the bladder neck, like a curtain coming up from the floor. Benign enlargement intrudes or "sticks" into the lumen of the prostatic urethra or bladder; cancer usually involves the floor, but it may grow into the urethra and produce any type of obstruction.

A cystogram and urethrogram are sometimes used as adjuncts to diagnosis to determine the amount of intraurethral and intravesical intrusion.

In making a diagnosis of prostatic obstruction, residual urine is determined, the blood urea, N. P. N., and creatinin estimated. Either the P. S. P. or indigo-carmine test is used to determine the kidney function. An x-ray of the entire urologic tract will add necessary information, obtainable in no other way.

Treatment

The treatment depends upon the type of obstruction and the condition of the patient. There are 2 methods of relief: transurethral electrosurgery and the open operation (prostatectomy).

Indication for transurethral operation:

(1) Fibrous prostatic bar.

(2) Obstructing fibrous scar following prostatectomy.

(3) Carcinomatous infiltration of the floor of the bladder neck.

(4) Slight to moderate benign enlargement of the prostate.

(5) Possibly, marked enlargement, with a serious medical condition precluding prostatectomy.

Indications for open prostatectomy:

(1) Marked intraurethral prostatic enlargement.

(2) Marked intravesical enlargement.

(3) Carcinoma producing a marked narrowing of the prostatic urethra.

Today a majority of patients may be relieved by transurethral methods. When I spoke before your society 3 years ago I was operating upon minor obstructions. With the advent of the more powerful cutting current during the past 2 years, I am operating upon moderate-sized obstructions. Increasing the cutting power of the current has increased the dangers of the operation many-fold. The electrode will pass through the tissues as a hot knife passes through butter. Certain urologists and general surgeons have, to their sorrow, listened to the sales talk of the instrument manufacturers. These surgeons have permitted their enthusiasm to triumph over their judgment and one hears of ruptured bladders, ruptured bladder necks, permanent incontinence, and death from hemorrhage and sepsis.

For fibrous bars, scars, and carcinomatous obstruction, I am using the knife electrode through a 24-F. cysto-urethroscope, excising the floor of the prostatic urethra. For slight

to moderate intraurethral and intravesical benign enlargement, I use the loop electrode for the lateral and median lobes, and the knife for obstruction at 6 o'clock.

If, at cystoscopy, the patient bleeds readily, if instrumentation is difficult, or if the instrument passes only after using force, that patient had better have a prostatectomy. If one tried to perform a transurethral operation on this type of obstruction, bleeding would interfere with vision, and one might punch a hole in the bladder. Trauma from prolonged cystoscopic manipulation is dangerous. A 28-F. instrument sometimes tears the bladder neck, causing severe hemorrhage. Three of my patients have developed traumatic strictures following transurethral operations with a 28-F. sheath. This large instrument split the bulbomembranous urethra and the resulting scar markedly encroached upon the urethral lumen.

Occasionally one sees a patient with a large prostate who has some medical complication such as marked diabetes, cardio-vascular disease, or a chest condition. On this patient, a prostatectomy must not be performed. If the instrument can be passed down the urethra easily, palliative relief can, in most instances, be given. A reduction in the residual urine usually follows.

I prefer to do a 2-stage suprapubic prostatectomy for marked prostatic enlargement. In private practice it is possible to send patients home between stages, for 1, 2, or 3 months. In Bellevue practice (no one wants "smelly grandfather" around the home) we are forced by economic conditions to keep things moving. Here the mortality rate is 18%.

Results

When the prostatic obstruction is efficiently excised by electricity or removed by enucleation (open prostatectomy), the patient empties his bladder without urinary symptoms. The serious back pressure on the kidneys and ureters (causing hydronephrosis, hydro-ureter, and sometimes pyonephrosis) is relieved. The mild or severe uremia, high blood constituents, and cardio-vascular disturbances are no longer present.

Looking back upon my results in about 900 transurethral cases during the past 10 years, I have concluded that it is wise to recommend early operation before serious kidney and heart lesions develop. One week ago I excised a fibrous bar upon a patient, aged 46, for Dr. Haines at the Guthrie Clinic in Sayre, Pennsylvania. A pyonephrotic kidney had been removed from this patient 3 years previously. This kidney had been destroyed by back pressure and by infection as a result of prostatic obstruction.

In my group of clinic and private patients, the mortality rate was 0.4%. A record of the 4 deaths follows:

H. G., aged 82, who had carcinoma of the prostate, died from pneumonia 2 weeks after operation.

H. C., aged 60, who had extensive carcinoma of the prostate, died from paralytic ileus 3 days after operation.

H. F., aged 55, who had moderate benign enlargement, died one week after transurethral operation. A peri-urethral abscess developed shortly after operation and the patient died after drainage of this abscess.

P. G., aged 73, who had moderate benign enlargement, died from pneumonia, gangrene of the lung, and bilateral parotitis one month after operation.

Instrumental Trauma

J. B., aged 70, a doctor's father, with moderate benign enlargement, needed an immediate suprapubic cystotomy following a transurethral operation. The 28-F. cysto-urethroscope had to be forced through the bladder neck. The floor of the bladder neck was torn by the instrument. One month after operation, while about his home, he had a cardiac attack. Following this, his convalescence was uneventful.

Two patients developed serious primary bleeding; the clots were removed with a Bigelow evacuator. An indwelling catheter controlled further bleeding. From 2 patients with severe secondary bleeding on the tenth and fourteenth day, clots were evacuated; bleeding was stopped with an indwelling catheter.

One per cent. of my patients required a secondary transurethral operation to relieve them of their obstruction (I had not removed enough tissue). These were early cases oper-

ated upon for bar; intraurethral lobes developed later.

I have told you more about dangers and complications, because I think we learn more from these than by boasting about good results. Suffice it to say, the vast majority of the 900 patients were relieved of their urinary symptoms—some for as long as 10 years, and we hope, for many more years to come.

Summary

(1) A patient with prostatic obstruction is in a serious condition, and if surgery does not intervene, the patient will die of back pressure, hydro-nephrosis, and uremia.

(2) A catheter life, with the attendant infection, leads but to the grave.

(3) When urinary symptoms first develop —before serious kidney damage has taken place—is the time to remove the obstruction.

(4) When it is possible, use transurethral electrosurgery. When this is impossible, perform a 2-stage suprapubic prostatectomy.

(5) Electric excision of prostatic obstruction should be performed by a thoroughly trained cystoscopist.

(6) The relatively few complications, the low mortality rate, and the relief given to a large group of patients, seem to recommend transurethral surgery most highly.

DISCUSSION.

Dr. A. H. Lippincott of Camden: It certainly is refreshing, even to a urologist, to hear so much about the 2-stage operation for bladder neck obstruction. It does seem sometimes that the urologist has sort of run wild on this transurethral resection operation. No doubt as time goes on and they have time to examine their postoperative results this procedure will fall into the place where it belongs. It has a field and a great one but it will not do all the things some of the men doing it think it can. I personally do not believe it can be used in all types of obstruction.

Dr. Collings is one of the pioneers in this work and I am glad to hear him take the stand he does tonight, to bring down this field for the transurethral operation to almost where it belongs. I have done a few but not enough to speak with any authority and my experience with it has not been to my satisfaction. Possibly I am not skilled enough in cystoscopy, as some of these New York gentlemen are, and, not being an electrician, I don't know much about using the instrument. There are some brilliant results and others not so good. I have noticed a great deal of dysuria following the operation. In one case it lasted over several weeks with a lot of infection, pain, and distress, and eventually I had to bring him back to the hospital where I could give him better attention, irrigation and so forth. Now the urine is practically clear. In another case we had to take the median lobe away, which we did without any other damage, but the symptoms were worse after than before. He lives down here in South Jersey somewhere. We brought him back to the hospital with the idea of doing a suprapubic operation. When cystoscopy following the transurethral resection was done, we found the lateral lobe had fallen into the bladder. While he empties his bladder, he has an enlargement, and we were going to operate, but following the cystoscopy he had some mental confusion for several weeks and we were not able to go on with it. There are many cases that can be relieved to a certain extent without submitting to a larger operation. I like the suprapubic enucleation and I like to do the 2-stage operation. In a few selected cases I do the 1 stage. Any case not tolerating the catheter, I do not waste any time with. Bladder operations we do mostly under infiltrating anesthesia but for the prostates I like the low spinal.

Success depends entirely on the pre- and postoperative treatment not on the operation. All my cases have a bilateral vasectomy. Care in getting ready for operation is the great thing. Up at Cooper Hospital we have a heart man go along with the case, and we are getting pretty good results.

We also watch carefully the intake and output—where the intake is very much greater than the output we usually drop the amount of fluid given, but we do give a great deal of water.

We cannot say a patient will be ready for operation in a week or 10 days—none are ready before 2 weeks. I have a patient who just came back with a suprapubic tube which has been in for 4 months, and another old colored man I operated on today who has been in the ward for 3 months.

I would like to see the enucleation operation brought back. I believe personally it is the real operation.

I can recall a member of our Staff with carcinoma of the prostate with dysuria. Dr. Collings operated and gave him absolute relief with no further urinary symptoms. So there is a field for all these types of operation—it is just a question of being able to judge which is the one indicated in each case.

Dr. Carl M. Scott: I have nothing to add. I think we have listened to 2 very informative and conservative papers. As time goes on, the resection operation is only a few years old, and data are accumulated, it won't be long before we can pick and choose the type of operation for each case. A good many years ago when I first started, the 2-stage operation was just coming in. It was customary then to operate at once, but after the PSP test came out we began to give more attention to preoperative care and the mortality rate dropped from 50 to 4%.

Dr. J. A. Summers of Cleveland, said that he was sure that the preoperative care had a great influence on the mortality rate and mentioned some cases that were done without any drainage or preparation and the mortality rate would certainly not stand up against Dr. Collings 0.4%.

Dr Cooney emphasized the necessity for care and the importance of blood chemistry, PSP, and other urinary findings in these patients before operation, and also the condition of the cardiovascular system.

He mentioned having the privilege of seeing a radical resection done in Iowa, and said that the case would have been rejected here. He said they are very much more cautious here in the East than

out there. He said he thought the transurethral method should be given a fair trial and that everyone knew that a great many of the cases would come to the 2-stage operation later. He mentioned a covered obturator manipulated by a button and giving the same curve as a Van Buren sound which decreases trauma and postoperative trouble to some extent. He also mentioned a retrograde visible lens which allows the operator a full view of the bladder neck. Dr. Cooney feels that the whole thing is in a state of flux and eventually will come down to its proper place.

Dr. Conaway mentioned being at the Pan-American Congress and stated that the men from the different countries all had their preferences—one for one operation and the other for some other type.

Dr. McGeehan said he had greatly enjoyed the papers and that he was sure that all the trouble we are going through now would be justified when we would be able to take our pick of the different types of operation for these cases.

Dr. Darnall brought back memories of the days when general surgery was done by 1 man who did mastoids, prostatectomies, head cases, appendectomies and all the rest. He said they always wondered why so many prostatic operations were fatal, but now that they know all the important preoperative care that is necessary, it is not surprising that so many patients were lost.

Dr. Shivers: Dr. Mackinney has had a very wide and varying experience, and after all we gain our real knowledge only from experience, so I think we can take as Gospel truth what he says.

Several years ago I had the privilege of spending some time with Sir John Thompson Walker in London. I was very enthusiastic over his technic, the 1-stage operation, possibly because I had been able to study quite a few cases that had been visitors to Atlantic City shortly after their operations, and I had the opportunity of cystoscoping them.

I found in many instances a persistence of infection; the cause for this probably, in addition to infection of the seminal vesicles, was nodules of prostate left behind in doing the blind operation.

Thompson Walker does the enucleation of the gland after the operation, uses the bladder retractor, places the patient in the Trendelenburg position. This gives an excellent view of the prostatic cavity. He removes all tabs of tissue and prostatic nodules. These are the cause of irritation of the bladder later. When these patients are cystoscoped a month or so after the operation there is a great difference between these cases and the ones operated on blindly.

I used to do a number of transurethral operations but found my mortality rate creeping up and I decided to select my cases. We do the 2-stage operation on practically all cases at this time. Our mortality rate is higher than Dr. Colling's after the suprapubic operation than after the enucleation of the gland.

It is my habit in doing the first stage to strip the bladder almost to the dome making the opening wide so that I have not to disturb anything in the second stage. These cases show very little reaction: no rise in temperature or pulse rate.

I was interested in hearing what Dr. Mackinney said about packing the prostatic bed. For a time, that was my custom until I got a severe hemorrhage on removing the packing which could not be controlled and the patient died. Since that time I have been introducing in all cases, whether they bleed or not at the operation especially if the blood pressure is high and drops during the operation, a Pilcher bag into the prostatic cavity leaving in an 18 or 20 rubber catheter. We pull it up into the wound and suture it and pull the bag into place. Whether we inflate it or not depends upon the bleeding at the time of operation. If the pressure has dropped we know that there will be trouble and we then inflate the bag.

In removing it Dr. Keyes taught me a trick saving a lot of trouble. We suture the catheter in the bag and draw the catheter into place attached to a piece of silk thread and if it is necessary to reinsert the bag within the next 24 hours it can be done without taking the patient to the operating room.

We have a pioneer with us in transurethral surgery. Dr. Collings deserves a lot of credit for developing that type of operation. This should only be done in certain selected cases and should not be attempted in enlarged prostates.

Dr. Mason and I had a man in the hospital who had retention of urine and on examination we found a large prostate. We inserted a catheter and gradually decreased the retention. We found a large mass in the right scrotum which we thought was a hernia but at operation we found he had a bladder in the hernial sac. Dr. Mason did a very beautiful operation and though the man was about 75 and had a bad heart he lived. He was turned back to the GU service and was in no condition to do a major operation so we tried to do a transurethral resection of the median lobe. After cutting out 3 or 4 pieces he developed a hemorrhage which was controlled and I was satisfied to quit so I removed the instrument and put in a catheter. It was removed after 4 days and he could pass a little urine but we reinserted it. After 3 weeks he had improved, had no reaction from the transurethral procedure so we decided to do a 2-stage operation which we did and he has recovered. We have not made a mistake by waiting but many are made by not doing this.

As Dr. Mackinney has pointed out it is very important to prolong the preoperative treatment and make sure the patient will stand the procedure.

We have had very good results with transurethral resections but we have not attempted to do this operation except in a few selected cases. We had 1 case that started to bleed 3 or 4 weeks after leaving the hospital and was bleeding for 24 hours before a doctor was called. We tried to evacuate the clots through the urethra but could not, and we did a suprapubic cystoscopy. The bleeding was very slight and could easily have been controlled had the patient returned in time and had a catheter inserted.

We must keep from traumatizing the deep urethral wall. I have seen ulceration 2 months after resection. This is a simple procedure but not without danger, and any man who attempts to do transurethral surgery should be prepared to do complicated surgery.

Dr. Mackinney: I have very little to discuss. I grew up in suprapubic surgery, and I think that entirely from a urologic standpoint we lean a little too much toward one type or another.

In dealing with the electroresection we are dealing with something new but with something that has a very definite place, and I am delighted to hear such papers as Dr. Collings has presented because he has given the true aspect of what will develop in the field of transurethral resection. It will come to a happy medium where we will be able to say this is a case that can be operated upon this way or that.

I know that there is some difference of opinion

as to the control of hemorrhage following a suprapubic operation. We can get away with a few cases without making any great effort to control it, but I feel sure that when I pack a prostatic bed with gauze I use the most effective precaution against bleeding. There may be some trouble when it comes to adjusting the bag, and I feel much safer by packing the bed than by using bags, and while I do not say that this is the best method in hospitals equipped with a good urologic service, it is more successful in the general hospital.

I am very glad to have come down to Atlantic City and am particularly pleased because of my contact with Dr. Collings on transurethral surgery.

Dr. Collings: I would like to thank you for being so indulgent in asking me to speak this evening.

Dr. Mackinney has mentioned some very valuable points in the preliminary treatment. I think it much more important to prepare your patients well. Then you never have the headaches and sorrows you do get when you rush in. There are men who have taken in patients with acute retention of urine, and even gone ahead with patients in uremic coma. The mere cystoscopy may often push such a patient over.

Dr. Lippincott says transurethral surgery will eventually find its own level. I made the same remark after I returned from Europe in 1921 when a man in New York said the days of the prostatectomy were over. I am sure he was wrong.

Dr. Lippincott says he has seen 3 weeks of dysuria. We have some last as long as 3 months. We do not pass the catheter until after 3 weeks.

One thing about Dr. Mackinney's paper—with proper preliminary treatment and urethral catheter drainage until the patient is able to walk about the ward with the catheter, if you do a suprapubic operation you know what is going to happen. If you do a transurethral resection with the electrode you don't know what is going to happen. As to anesthesia the pendulum swings one way or the other. Spinal anesthesia works well but just on the case you don't want it to the patient gets a violent reaction and dies.

Dr. Conaway has been down to the Pan-American Congress and they have their preferences too. We were trained in the school of Keyes and do not believe in Young's method, we do not have the perineal passion!

THE CARE OF THE PROSTATIC PATIENT*

H. H. Goldstein, M.D.,

Elizabeth, N. J.

No attempt will be made to discuss the operative procedures for prostatic hypertrophy. Only those factors dealing with preparation for operation and after-care will be considered. Many of the subjects are practical and well known to the urologist; several, the general practitioner and general surgeon should heed; all will certainly bear repetition.

The surgical hazard attendant on the prostatic patient overshadows by far the usual risk encountered in general surgery. It is interesting to note, in passing, that the genitourinary surgeon today subjects to major surgical procedures patients to whom the general surgeon would hold out little hope. This is accompanied by a naïve nonchalance nothing short of remarkable in view of the mortality rates of 1 or 2 decades ago. It appears that with the realization of inferior surgical risk there has also come the realization of the necessity of infinitely greater attention, both preoperative and postoperative, to this type of patient. Herbst in his presidential address aptly sums up the situation in the statement, "It is not so many years ago that the mortality following removal of the prostate gland was so high that many of us would prefer not to be reminded of the rather incomplete statistics of those days."

The advent of transurethral prostatic resection has not and probably will not revolutionize prostatic surgery. The procedure simply adds to the surgical armamentarium of the urologist another method of attacking certain types of hypertrophied prostates with greater ease, lower mortality and fewer complications. The operation will probably prove most valuable in the hands of competent instrumenteurs who realize that the prostatic resector is not a panacea for all types of prostatic enlargement. The preoperative preparation does not deviate from those fundamental ideas governing prostatic surgery which have been evolved by years of assiduous attention to the problem.

Prophylaxis is limited by our scanty knowledge of the etiology. Because of the underlying anatomical consideration little benefit may be expected from drugs. The earliest symptoms, unfortunately disregarded by most patients, are of utmost importance. The onset of frequency and nocturia should be viewed with suspicion, and the beginning of a residual urine marks the first step in bladder decompensation. In spite of a slight increase in frequency, the patient should be urged to empty his bladder regularly and to avoid holding his

*(From the Department of Urology, Alexian Brothers' Hospital.)

urine for long periods of time. Frequently this will prevent the onset of an acute retention and it certainly delays the pathological changes in the bladder, ureters and kidney pelves which are secondary to back pressure. The patient should be cautioned against straining and the urine should be kept as nearly normal as possible to prevent prostatic congestion. As a rule the normal urine is acid, but when infection exists it usually becomes alkaline. Alkalinity, hyperacidity or increased concentration may cause symptoms or aggravate the existing condition. Restricting fluid intake in order to lessen the disturbing frequency is dangerous; it may increase the urinary solids, irritate and congest the bladder and prostate, and severely tax the kidneys.

Age, *per se*, is no contraindication to prostatic surgery. The aged prostatic of 80 or 90 demands and deserves surgical interference if he has the blood chemistry, renal function and general physical condition commensurate with successful prostatectomy.

Palliative treatment consists in the main of symptomatic relief; it involves catheterization for retention, and treatment for cystitis, or any other complication which may arise. It is wise, however, at all times to bend our efforts to the ultimate cure which is afforded by surgery; with this in mind, each step in the treatment should tend to minimize the prejudice against successful operation.

Many patients present themselves suffering from acute retention. The question of catheterization becomes one of prime importance and the advisability of decompression must be considered. Catherization should always be attempted first with a soft rubber catheter. This is almost foolproof for the risk of urethral trauma is at its minimum. When it is impossible to get a soft rubber catheter by the enlarged prostate, a silk-woven catheter is used. In this field the natural curve, coudé, bicoudé and flat coudé stand at the top of the list. Trauma may easily be prevented during the use of these catheters if one does not push and haul too vigorously. Catheterization always should be performed with the acme of gentleness. At times it is impossible to slide even a small silk-woven catheter by the prostate. In these cases we have recourse to other methods. Frequently it is advantageous to pass a filliform and followers. Occasionally a silver catheter introduced with great gentleness will pass where a flexible catheter will not. Very often during catheterization the vesicle sphincters will clamp shut, preventing the catheter from sliding by the prostate. In such a case, hold the catheter firmly against the sphincter and wait a short time until it relaxes; then the catheter slides into the bladder very easily. When other methods fail, one can occasionally get into the bladder with a soft rubber catheter through which sterile oil is injected to balloon out the urethra as the catheter advances. Perhaps the worst cases are those in which someone, by unsuccessful catheterization, has created a false passage. These cases tax our resourcefulness and ingenuity. At times we are fortunate in being able to catheterize them without undue difficulty, but more often we cannot do so and must resort to cystotomy—especially when there is bleeding and the bladder is filled with clots.

If the retention is of only short duration and the bladder only moderately distended, it is usually safe to empty the bladder completely. On the other hand, in those cases of large chronic distention, it is dangerous to empty the bladder too quickly. Here decompression is advisable. Decompression may be accomplished in many ways. A simple method is to insert into the bladder a No. 6F ureteral catheter and allow the bladder to decompress by the drop method. Young's gravity decompression apparatus or the Y tube atmospheric decompression apparatus may be used. The bladder may also be decompressed by periodically releasing small quantities of urine, keeping the catheter clamped in the interim. It is, perhaps, wise to release not more than 1 oz. of urine at first, followed in 15 minutes or a ½ hour by another ounce. The quantity of urine released and the time interval can then be changed gradually so that the bladder is emptied fairly rapidly and safely. It has been found that the release of 1 oz. of fluid from the distended bladder reduces the intravescicle pressure almost 50%. Rapid emptying of the bladder with the resultant tremendous fall in intravesicle tension which is also transmitted

to the kidney pelvis is responsible for the sudden collapse which we occasionally encounter. It may be necessary to empty the bladder very slowly at times, and I recollect one case which required 9 days before the patient was unhooked from a gravity decompression apparatus.

The bleeding bladder presents a serious obstacle to decompression. When the bleeding is severe, it is almost impossible to decompress, for the blood coagulates very rapidly and the bladder is soon filled with a large mass of clot. Urethral drainage is insufficient in these cases and should not be attempted. At times it is possible, through a large bore catheter with a powerful suction syringe, partially to empty the clot. When this method is ineffective and the bleeding persists, it becomes necessary to open the bladder suprapubically, remove the clots, and, if possible, find and ligate the bleeding points. Frequently suprapubic cystotomy with drainage is alone sufficient to stop the bleeding, but occasionally packing is necessary. It is wise to irrigate the bladder through a suprapubic tube, if the bladder has not been packed, to prevent further clotting. At times it is necessary to transfuse because of large blood loss.

After the bladder has been emptied, either by decompression or by catheterization, the problem of using an indwelling catheter arises. Some patients, even in the face of a mild urinary infection, do well without drainage, and cystotomy may be performed as soon as the patient is diagnosed in respect to blood chemistry, cystoscopy, cystography, etc. In most cases, however, in which there is a large residual of infected urine, preoperative drainage is most important simply as a surgical procedure to remove the pus. Usually it will be possible to drain through a urethral catheter and the patient need not be subjected to surgery until the blood chemistry and renal function become approximately normal. In those instances of exceedingly dirty bladder, which would probably not be adequately drained per urethra, do an immediate cystotomy for drainage.

Bladder calculi complicate the procedure. Drainage per urethra of the stone-bearing bladder is notoriously poor. In these cases one may be forced to do a cystotomy and drain through a suprapubic tube after removing the stones. Occasionally one encounters a prostatic with a huge vesicle calculus, urinary retention, poor renal function and high N. P. N. The operative mortality of large bladder calculi alone is high and this fact added to a low renal function and a high nitrogenous retention in the blood contraindicates operation. Such a patient, presenting as he does many unfortunate features, should be drained per urethra in spite of the vesicle calculus, in an attempt to decrease the N. P. N. and raise the kidney function. If this is not done it is almost certain that the results of surgery will be most unhappy.

Cases which have only a small residual of uninfected urine uncomplicated by stones or blood clots raise the question of 1-stage and 2-stage prostatectomy. Any consideration, however, of a choice between the 1-stage and the 2-stage operation must be tempered by the realization that the 2-stage procedure is more or less foolproof, while the 1-stage operation is always attended by risk and danger. We are told that if the individual is robust and healthy, the 1-stage operation may be done. It is true that some urologists strongly advocate 1-stage prostatectomy but it seems, nevertheless, that any loss of time necessitated by increased hospitalization in the 2-stage operation is far overbalanced by the increment in risk which attends the 1-stage procedure. It is well to remember that prostatectomy is never an emergency operation. If the individual is not of the robust, healthy type; if the urinary function is diminished and the blood chemistry is not normal; it is wise to put the patient on catheter drainage and do a 2-stage operation when the laboratory reports normal findings.

The opinion has been voiced that the urethral catheter produces a certain amount of infection in the bladder and urethra and that this infection, although very mild in character, usually serves the very important function of causing partial immunization of the patient. When, on operation, the blood stream is opened to this infection, the patient has already become immunized to a certain extent and is in a position to withstand the operation with greater ease. Certainly this is not true

of a 1-stage operation of this nature without previous drainage. In such a case we have a patient who surgically is only a fair risk, whose renal function and blood chemistry are not normal, and who is exposed suddenly with a lowered resistance to the infection which follows prostatectomy. The rôle played by infection brought about by the urethral catheter and its reflection in our mortality statistics has not yet been determined. Certain it is that infection is produced in the preoperative treatment of the prostatic by the indwelling urethral catheter, and equally certain is it, that this infection may extend not only to the prostate but also to the seminal vesicles, bladder and upper urinary tract. In this relation, Herbst has properly raised the question of thrombosis of the prostatic and periprostatic veins followed by pulmonary embolism as a factor in prostatic mortality. These are all problems of tremendous import to the prostatic patient, but in the final analysis, in spite of prejudice and conjecture, urethral drainage, although a recognized evil, remains as one of our strongest bulwarks and greatest assets in preoperative preparation for prostatectomy.

A 2-holed, hollow-tipped, soft rubber catheter is the best for urethral drainage. The 1-holed, whistle-tipped catheter is made of more unyielding rubber, has the disadvantage of only one eye, which may easily become plugged, and the additional disadvantage of a solid tip which makes its insertion with a stylet impossible. The largest catheter which the urethra will accommodate should be used, for the catheter, in strict accord with the best principles of surgery, is a drain for a pus-containing cavity and should provide adequate drainage.

The patient with an indwelling catheter is usually quite comfortable. An occasional individual complains bitterly—for the catheter is irritating to the mucous membrane of the urethra. (Any retention catheter will produce a low-grade non-specific urethritis.) Usually we find that a urethritis is present and that pus will either flow freely from the urethra or can be expressed from it. At times this may assume serious proportions. It is wise to remove the catheter every 4 or 5 days and, after irrigating the anterior urethra, to replace it.

The catheter with its attached drainage tube is heavy and drags on the penis. To avoid this, the drainage tube is pinned to the bed-sheets, allowing a generous slack for movement; the drainage bottle can easily be placed on either side of the bed when the patient wishes to turn. To facilitate inspection of the drainage at a glance the bottle receiving the urine should be of transparent glass. A metal urinal or an amber-colored bottle makes inspection difficult. The catheter should not be strapped in too tightly or edema of the glans and preputial skin will ensue. The drainage tube is best placed over the thigh rather than under it so that kinks and faulty drainage due to pressure of the thigh may be avoided. Many small things can be done to make life easier for the patient and frequently strict attention to minor details such as these spell the difference between a fairly comfortable convalescence and a stormy one. One cannot emphasize too strongly the importance of attention to detail in the handling of old prostatics and the tremendous aggregate benefit which they derive.

Bladder irrigation has been the subject of much discussion. Some urologists make daily or twice daily irrigations a routine. I believe we all irrigate the very dirty bladder until the urine is relatively clear, but after that, irrigation as a routine is superfluous and in some cases is instrumental in stirring up infection. Dirty urine is a signal for irrigations; they should be discontinued when the urine is relatively clear. Boric acid solution or even sterile water is perhaps as good an irrigating fluid as any. Strong antiseptics irritate the bladder and mercurochrome, even in low concentration, is a powerful irritant. Acriflavine or Rivanol may be used to advantage. In the final analysis, however, one cannot hope to sterilize the bladder, and greater advantage is obtained by frequent irrigations and by the mere mechanical effect of washing. In some cases where, as a result of chronic distention of the bladder, ureteral reflux is present, frequent irrigations may stir up a pyelonephritis. Should this occur, irrigation is contraindicated and should be discontinued.

Vasoligation is now performed by most surgeons. Before the days of this procedure we saw many cases of secondary epididymitis, but

the incidence of this condition is now much lower. Some urologists merely tie the vas, some simply cut it between 2 ligatures, while others remove a small portion of the vas. It appears that removal of a small section is safest. It has been shown that epididymitis can be caused by infection through the lymphatic channels. Therefore, it behooves us to interrupt the lymphatic drainage while doing our partial vasectomy. It is best to ligate the vas before any instrumentation of the urethra but unfortunately this is many times impossible and we are obliged to wait until after catheterization.

The bowels should always be kept open. Each of us has his own favorite method of catharsis. Daily enemas may be employed to advantage, but their use is attended by the danger of producing a sluggish bowel prone to constipation and distention. Any of the mild cathartics like cascara, milk of magnesia, licorice powder, etc., will usually be efficacious and they may be supplemented by enemas as occasion demands.

During the patient's entire stay in the hospital every attempt should be made to keep him out of bed—in a wheel-chair if he is unable to walk. Before operation there is no reason for keeping the patient in bed and after operation he should be in a chair as soon as this is compatible with his condition. Too long a stay in bed increases the incidence of pulmonary complications due to stasis. The patient who is bedridden should be turned from side to side and aided in sitting up in bed in an attempt to prevent stasis. It is true, of course, that pulmonary and coronary embolus are 2 powerful reasons for keeping the patient in bed for a longer time than may otherwise be necessary; but this is the lesser of 2 evils and we ought to institute prophylactic measures against those complications which we suspect may occur.

All too frequently a bad heart complicates the picture, adding a tremendous hazard to surgery. Operative intervention should be postponed until the cardiovascular system is stabilized if possible. Cardiac decompensation, auricular fibrillation and other cardiac arrythmias are contraindications to prostatic surgery, and it will be found that it is usually best to make every effort to stabilize the heart before attempting operation. In obscure cardiac arrythmias it is often wise to obtain an electrocardiogram.

One does not operate on a prostate until a more or less detailed investigation has been undertaken. Some are satisfied with rectal examination, others add a cystogram. Some examine the prostate cystoscopically and per rectum with or without cystographic studies. It seems to me that every case deserves rectal examination. This should be followed, in due course, by cystoscopy and if necessary by examination of the urethra, for many prostatic enlargements are partially or wholly intraurethral. A cystogram should also be done on each case. This gives a graphic idea of the size and position of the prostate, the thickness of the bladder wall, and frequently discloses a diverticulum which was missed at cystoscopy. Some urologists depend largely upon the cystographic examination, while others insist on actually seeing the prostate upon which they will later operate. Both methods of diagnosis may be used to advantage and no sympathy is due the general surgeon who, without cystoscopy, blood chemistry and renal functions has the audacity to perform prostatic surgery.

Perhaps the most important problem in prostatic surgery is the estimation of the time for operation. To this end many criteria have been used. On the Continent the urea concentration in the urine, the Mosenthall test, and daily determination of specific gravity of the urine are employed. In this country more attention is paid to the blood urea concentration and the phenolsulphonphthalein output. Many of our patients have high blood non-protein-nitrogen and poor phthalein outputs, but after a shorter or longer period of drainage the non-protein-nitrogen is reduced and the phthalein output increases. It may require several weeks before these findings are normal and it is always wise to withhold operation until they are normal, or very nearly so. If both tests are done at the same time we can see how, with drainage, the non-protein-nitrogen gradually decreases and the phthalein rises until the normal is reached. In some cases, there is a very close ratio between the two but more often one or the other will fluctuate independently.

However, a time will be reached when both findings are more or less stable.

Another factor, and perhaps a potent one, in determining the time for operation is the ratio between fluid intake and urinary output. Especially in those cases of large prostates with obstruction, one finds that the patient is taking between 30 and 40 ounces of fluid daily. On admission to the hospital, fluids are forced. After the first 24 hours, perhaps, one finds that there is a decrease in the output of urine. At this point the patient is storing his fluids. At the end of the second 24 hours, in spite of the fact that the intake has now reached, perhaps, 120 ounces or more, the output has fallen to a point much lower than it was on admission. At the end of the third day the output begins to mount and on the fourth day it rises tremendously so that at times it is greater than the intake and the patient unloads the fluid which he has previously stored. After this great rise in output there is a lesser fall below the intake and the patient now proceeds steadily at a relatively high intake and an output which is not much less than the intake.

Should this course of events persist, it is an indication that the excretory function of the kidneys is good and that the time for operation has arrived. This definite sequence of events may be interrupted by complications of various kinds. A rise in temperature may disturb the balance between intake and output, etc. The time relationships, stated above, may vary a great deal, but finally, at some point in the patient's course it will be found that the output rises above the level of the intake and then falls, running at a relatively high level for 3 or 4 days; the patient will then usually be found fit for operation, even without the confirmation of laboratory data. However, one always "checks up" through the laboratory.

Many people as they grow older have a dread of surgery. In some, this fear is so intense that permission for operation is vehemently refused, death being apparently preferable to surgery. Some old prostatics resignedly submit to operation, quietly stating that they are well aware that for them operation spells death. These latter patients develop fixed ideas on that subject, rejecting food and drink, lying listlessly in bed, refusing to respond and begging only to be allowed to die in peace and quiet. Unfortunately this wish is too often granted for it becomes impossible, at times, even with excellent nursing care, to arouse the patient from his lethargy which becomes deeper and deeper until death by concurrent infection or uremia ends the picture. This sequence of affairs may ensue even before operation; more frequently, however, the patient despairs of life because of the long intervals between drainage and cystotomy, cystotomy and prostatectomy. The answer to this problem is obviously a psychological one and the situation is never easy and occasionally impossible to handle successfully.

Urologists today realize the value of fluids at every stage whether preoperative or postoperative. Although this should not be carried to extremes, suppression is less often seen if the patient is receiving about 100 ounces of water daily. Before operation most patients will drink willingly enough but even then an occasional one refuses to coöperate. In some cases it is wise to administer 2000 c.c. of saline subpectorally the night before operation so that fluids need not be forced too soon after operation while the patient is nauseated. If possible, rectal fluids should be given. It is surprising how much fluid can be absorbed in this way. The patient can usually take 10 to 12 ounces every 4 hours, and 50 or 75 ounces of fluid taken in this manner relieves the stomach of a large burden. Rectal fluids may cause distention; in this case it is contraindicated. Both cystotomy and prostatectomy are shocking to the urinary system and there is much wisdom in giving the majority of our patients subpectoral fluids directly after operation regardless of whether or not they have bled. After a reasonable time if urinary drainage has not commenced, subpectoral fluids are immediately indicated and they should be continued until drainage begins. One should not be fearful of administering large quantities of fluids in this fashion and if suppression still persists, fluids, both subpectorally and intravenously, are forced to the point of edema, digitalis and caffein sodium benzoate being used to sustain the cardia.

A definite percentage of patients develops

hiccough after operation. This most distressing symptom is usually indicative of retained nitrogenous wastes in the blood and only one method of procedure presents itself; the hiccough must be washed out. This process consists mainly in forcing subpectoral and intravenous fluids to the limit, for it is well known that the kidneys can handle a dilute solution of blood more easily than a concentrated one. The systemic excretions may be complemented by forced sweating. Diuretics are of no avail. Carbon dioxide gas has been useful in some cases, but more frequently it fails to do the work. It must be remembered that hiccough in these cases is due to a toxemia and does not react to the many remedies, medical, physical, and spiritual, which apparently cure the occasional case of reflex hiccough.

Cystotomy calls for drainage. Of the 2 methods in vogue, the Marion drain and the Pezzer catheter, it is difficult to say which is better. The Marion tube usually presses against the bladder or enlarged prostate and may cause painful spasm or bleeding. The Pezzer catheter can be drawn up to the dome of the bladder obviating the bladder spasm and it can also usually cope with the situation when moderate bleeding is present. The operator is thrown upon his own initiative in the selection of a drainage tube, but the nervous, high-strung, sensitive patient certainly should not be subjected to the irritation of a large Marion drain.

Whichever form of drain is used, it should be securely pinned to the binder to prevent pulling of the long drainage tube which runs to a bottle at the side of the bed. The suprapubic drain should be irrigated and kept free from clots and pus. Irrigation is periodically carried out until the return is relatively clear.

As soon as possible after cystotomy the patient is encouraged to get out of bed and after a few days he can usually be in a chair or walking about. During this time the blood chemistry, renal function and intake and output are being studied in preparation for prostatectomy. When the temperature reaches and remains normal, when the non-protein-nitrogen and renal function become normal; and when the urinary output coincides more or less with the fluid intake, the patient is ready for the second step. Usually 10 to 14 days are required, but a much longer time may be necessary. It is not well to do the prostatectomy too soon after cystotomy and it is always best to subject these old men to a little surgery at a time, allowing enough time between each step for complete recuperation.

After the prostate has been removed, the question of hemostasis arises. If the prostatic bed does not bleed, it is sufficient to insert an adequate suprapubic drain and nothing else. If there is oozing or bleeding, the prostatic bed can be packed with gauze and good hemostasis secured. Many urologists use the various hemostatic bags. The Picher bag lends itself admirably to this purpose. It is inserted with ease, gives good hemostasis, is adjustable and can be removed in 24 hours or less. In removing the bag, one should first deflate it and wait for about an hour. If the prostatic bed is going to bleed, it will usually do so during that time and it can be checked by simply inflating the bag and allowing it to remain in situ for another 10 or 12 hours. Usually 24 hours is ample time. At the end of this period it is almost always safe to remove it. In removing the bag a urethral catheter is threaded to the end of the tube and as the bag is removed the catheter is drawn into the bladder with the same motion. The catheter is then adjusted and strapped to the penis, and without further trouble or trauma to the operated area we have our patient on urethral drainage and the process of healing the suprapubic wound is under way.

As the wound edges heal and are covered with healthy granulations they may be strapped with adhesive and approximated. The urethral catheter is kept free by irrigations and in a short time the catheter is carrying the drainage; the patient is dry suprapubically, and the wound, no longer bathed in urine, is healing rapidly.

When the suprapubic wound is closed, and the patient has been dry for 4 or 5 days, the catheter is removed. For the next 2 or 3 days, however, the patient is asked to void every 2 hours. If he is unable to do this, he is catheterized, and if stricture is found at the vesicle neck, dilatation is instituted. After 2 or 3 days the residual urine is determined, and if a

residual of more than 3 ounces is found, the catheter is reinserted and the atonic bladder given a chance to contract.

Some patients have full control of urination immediately after removal of the catheter. Most patients, however, are partially incontinent for a few days, and these are instructed to exercise the sphincters in an attempt to regain control. The best exercise for this purpose is to stop and start the stream repeatedly during the act of voiding. In this way the muscle tone improves, the incontinence soon disappears, and the patient is cured.

ANTIVENIN THERAPY IN PURPURA

A Case Report

Reeves B. Van Duzer, M.D.,
and
C. Abbott Beling, M.D.,
Pediatric Service of R. Hunter Scott, M.D.,
Newark City Hospital,
Newark, N. J.

This case is reported after 11 months of observation to show the apparently successful use of antivenin in the treatment of idiopathic purpura hemorrhagica.

Toby L., a white male, 9 years of age, of Italian parentage, was admitted to the Newark City Hospital on December 17, 1931, suffering from prolonged epistaxis. His parents were living and well. There was no hereditary history of abnormal bleeding of any kind. He had always been well, except for pertussis, measles, and pneumonia. Six years ago, following the pneumonia, some enlarged cervical glands were taken out without any recurrence of glandular enlargement. He has had occasional colds and sore throats but no previous epistaxis, no bleeding from the gums, prolonged bleeding from cuts, or unusual ecchymoses. There was no history of tuberculosis or rheumatic fever.

Three days before admission, the patient's gums began to bleed abnormally following the extraction of a tooth. The bleeding continued up to the time of admission, accompanied by severe epistaxis. He became increasingly pale and weak. Just prior to admission numerous petechiae were noted, especially on his arms and legs. Up to the onset of bleeding, the boy had been perfectly well, according to his parents.

Physical examination showed a well-developed male, 9 years of age. The fundi and pupils were normal. Old fading petechiae were noticed in the lower part of the left conjunctiva. There was fresh blood in each nostril and a bluish discoloration over the bridge of the nose, but there was no bleeding from the ears. The lips and tongue were pale and dry. There were a few carious teeth and a dry blood clot in the cavity from a recent extraction. Dried blood was also seen in the posterior pharynx. The lungs and heart were normal but the pulse was weak and rapid, 110 per minute. The whole abdomen was soft but moderately tender. The spleen was palpable and extended 2 centimeters below the left costal margin. There were numerous ecchymoses varying in age and size over the right forearm, left hip, right leg, and both knees; and many petechiae scattered over the body, most of them on the extremities and a few on the chest and abdomen. The skin was pale and dry. The application of a tourniquet to the left arm produced a shower of petechiae distal to it. There was a general glandular enlargement affecting chiefly the axillary, cervical, and inguinal lymph nodes.

Laboratory data on admission: leukocytes, 9400; polymorphonuclears, 76%; lymphocytes, 24%; hemoglobin, 55% (Sahli); erythrocytes, 3,200,000; moderate achromia, anisocytosis, and poikilocytosis. Platelets were absent in all smears. Most of the white cells were mature but an occasional young form was seen. The bleeding time was 7 minutes and the clotting time, 6 minutes. The urine was normal.

Treatment. On the day before admission, the patient had been given 2 doses of 10 c.c. each, of horse serum by a physician. During the first 10 days at the hospital he received 6 transfusions of whole blood in amounts varying from 250 c.c. to 300 c.c. for the first five, and 540 c.c. at the sixth. After each transfusion the bleeding ceased from 8 to 15

hours and then recurred each time more severely than before. He also received 8 intramuscular injections of thromboplastin. Transfusions were discontinued after the tenth day and for the next 2 days 8 intramuscular injections of coagulin were given. With all this treatment, bleeding from the nose and mouth was not checked. On the twelfth day he received 10 c.c. of Neartic crotalidae antivenin subcutaneously, having been first desensitized with small and increasing intradermal injections. Twenty-four hours later the bleeding had ceased entirely and never recurred. He has been free from abnormal bleeding for 11 months since his discharge from the hospital. After the bleeding had stopped, the treatment was followed up with sodium cacodylate—gr. 3, once a day, and iron, quinine, and strychnine, dr. 1, twice daily until he was discharged.

Prior to the administration of antivenin the temperature averaged about 104 with minor fluctuations; and the pulse, 140. Twenty-four hours later the temperature had dropped to 100 and the pulse to 110. The pulse, temperature, and blood picture gradually returned to normal, the platelets increasing in number. Now, 11 months after discharge, the blood picture is still normal and the patient is in good health with no evidence of recurrence. On one occasion since discharge he had a traumatic epistaxis which stopped normally in a few minutes.

Conclusions

This case suggests the following conclusions:

(1) Antivenin is apparently of value in the treatment of idiopathic purpura hemorrhagica.

(2) Horse serum itself is apparently not responsible for the result, as injections of it alone were without effect.

(3) The effect is probably due to a substance or substances present in the different types of antivenin, probably anti-hemolysins and anti-hemorrhagins, for in our case the result was obtained with Nearitc crotalidae antivenin, while those reported by Stockton and Franklin and K. P. A. Taylor were obtained with Bothropic antivenin.

AN ANALYSIS OF 10,000 OBSTETRICAL CASES

Raymond T. Potter, B.S., M.D., F.A.C.S.,
Assistant Attending Obstetrician, Orange Memorial Hospital,
Orange, N. J.

This survey covers the work of the Obstetrical Department of the Orange Memorial Hospital, Orange, N. J., from 1921 to 1932. There are 75 maternal beds, 55 for private and 20 for ward patients, and nursery accommodations for the same number of bassinets. With an increased hospital census more space is available without over-crowding. The Orange Memorial is an "open hospital" to the extent that any accredited physician may obtain courtesy privileges and care for his own private or semi-private patients. In 1921, 58 physicians were extended this privilege. This number has increased steadily and during the past 5 years the number of doctors who have cared for maternity patients in the hospital has averaged 79 per year.

The Obstetrical Staff consists of 1 Attending, 3 Assistant Attending and 3 Junior Obstetricians. All ward cases, or about ¼ of all maternity patients, come under the direct supervision of this staff. The delivery room technic and post-partum care is standardized. This results in uniform methods and procedures for ward patients. Staff members follow this routine in their private work. Until recently, there was no authorized or obligatory routine or supervision of the practice of non-staff or courtesy physicians who attend a large number of private patients. In order to systematize this work and thereby improve the results of the department as a whole, a consultation with, and the assistance of, one of the Obstetrical Staff is now required in all abnormal or protracted cases.

Classification of the 10,000 cases as regards parity and ward versus private distribution is as follows:

TABLE I.

Primiparae	4644	Ward	2333
Multiparae ..	5356	Private	7667
	10,000		10,000

There were 6867 normal deliveries—slightly more than 2/3 of the total. The remaining 3133 abnormal cases are divided as follows:

TABLE II.

Forceps applications:	
High	98
Mid	1103
Low and outlet	1292
Breech deliveries and extractions	368
Versions	85
Cesarean section	187
	3133

Forceps were used in about 25% of cases. These figures are totals for the entire series and do not properly show the incidence of forceps at the present time, especially as regards the use of high forceps. A comparison of the early years; i. e., 1921 to 1925, with the later years, 1926 to 1931, as shown in the accompanying table is more indicative of the present use of instruments.

TABLE III.

FORCEPS APPLICATIONS.

Period	Total Cases	High	%	Mid	%	Low & Outlet	%
1921-1925	3885	63	1.62	329	8.4	461	11.8
1926-1931	6115	35	.57	774	12.6	831	13.5

The number of mid and low applications has increased 4.2% and 1.7% respectively, whereas high applications have been made about one third as often as formerly. They are practically never used on the service now.

The incidence of breech deliveries was 1 in 27 cases or 3.68%. Including the versions performed for various reasons, the incidence is increased to 1 in 22 or 4.5%.

The end results as regards the babies in these breech cases show that 111 of the 453 babies were still-born or died shortly after birth—a gross mortality of 24.7%. Sixty of the 111 were premature (7 months or under) macerated or had deformities incompatible with life. Omitting these, leaves a corrected mortality of 51 or 11%. This mortality in breech deliveries is being reduced by the more prompt use of forceps on the after-coming-head and by insisting that at least 2 doctors be present at all deliveries of this type. Figured on the same basis, our fetal mortality in breech cases during 1930 and 1931 is 6.8%.

Cesarean section was performed on 187 patients. These were all of the classical or modified classical type. The reasons for this operation are shown in the accompanying chart.

TABLE IV.

REASONS FOR CESAREAN SECTION

Ward	Private
4—No dilatation or progress after test of labor	13
3—Eclampsia or threatened eclampsia (following conservative treatment showing no dilatation)	11
19—Contracted pelvis	22
1—Deformed pelvis (Naegele's)	
3—Flat pelvis	6
2—Accidental hemorrhage	5
Following cervical and perineal repair	2
Previous Cesarean	17
1—Primipara with breech presentation, no dilatation after test of labor	14
5—Placenta previa	9
Locked twins	2
1—Interfering fibromata	5
Occiput posterior in primipara	4
1—Transverse position of fetus	2
Uterine polyp	1
For sterilization at term	1
For living baby following numerous miscarriages or still-births	2
1—Vaginal atresia	
Chronic cardiovascular disease	3
1—Fetal dystocia	2
Following automobile accident (fractured neck and pelvis)	1
Vertex and feet presentation	1
No reason given	22
42	145

We regret the number, 22, for which no reason was given. These were all among early private cases and it was a hopeless task to attempt to interview the respective doctors and determine the reasons.

Analysis of this group shows Cesareans were performed on the average of 1 in every 53 cases. Morbidity following the operation occurred in 20 cases—10.6%. Six patients died following the operation from causes shown in Table V.

TABLE V.

MATERNAL MORTALITY FOLLOWING CESAREAN SECTION

Sepsis	1
Shock with hemorrhage	3
Pulmonary embolus	1
Paralytic Ileus	1
	6

This is a maternal mortality following Cesarean operation of 3.2% and accounts for 15% of the total maternal deaths in this series of cases.

Morbidity. The computation and report of statistics on morbidity in any series of illnesses or operations is of little value unless it conveys some picture of the patients' condition following a prescribed treatment or procedure. Standards for analyzing and recording are of value, not only in affording a basis of calculation but also as a means of comparing separate reports. Even then variations will occur, depending upon the interpretations of the statistician.

In the original tabulation of this series we arrived at what we have termed our "gross morbidity" by including all patients who had a temperature of 100° or more on *any 2 days* following the first 24 hours after delivery. The causes of morbidity are shown in Table VI. and give a rate of 7.98%.

TABLE VI.

MATERNAL MORBIDITY.

Ward	Private
1—Following manual dilatation of the cervix	1
7—Post-partum hemorrhage	25
16—Difficult labors and deliveries	33
13—Engorged breasts	55
3—Home or ambulance delivery (fever on admission)	
—Separation of symphysis with cystitis	1
6—Following Cesarean section	14
4—Eclampsia	14
1—Lacerated cervix	
2—Following induction	3
3—Retained placenta or blood clot	18
7—Phlebitis	16
1—Sapremia	2
2—Mastitis	15
Secondary anemia	2
3—Puerperal sepsis	3
6—Preëclamptic toxemia	13
1—Following placenta previa	8
1—Following accidental hemorrhage	4
Cystitis	4
Magnesium sulphate abscess	1
Septicemia following pre-partum infection (wire pessary in placenta)	1
14—Pyelitis	27
1—Parametritis	
2—Salpingitis	3
Acute nephritis	2
2—Following episiotomy	15
Evulsion of uterus (delivered at home)	1
Repair of double vagina	1
1—Metritis	1
89—Cause not given	267
2—Pulmonary T. B.	1
Otitis Media	1
4—Grippe	15
4—Bronchitis	3
2—Pneumonia	1
3—Tonsilitis	2
Appendicitis	1
1—Chronic endocarditis with decompensation	1
Intestinal toxemia	7
Gall-bladder disease	3
Pharyngitis	1
1—Herpes Zoster	
1—Alcoholism c acute dil. of stomach	
3—Parotitis	1
1—Glands of neck	
Abscess of hand	1
Pleurisy	2
208	590

This, we feel, does not truly portray the results of our obstetrical technic or the condition of our patients following delivery. If we utilize the standard for morbidity accepted by many writers, namely a rise in temperature to 100° or more on *2 or more consecutive days* not including the first day post-partum, we may deduct from our initial list 193 cases. These patients manifested a sporadic rise in temperature on non-consecutive days, had no complaints and there was no evident or demonstrable pathology. In addition to these there were 62 patients who had temperatures from determined causes which were definitely of non-obstetrical origin or sequelae. Deducting both of these groups leaves 543 cases, giving a "true obstetrical morbidity" in this series of 5.45 per cent.

A large number of cases, 89 ward and 269 private, showed temperatures on the charts with no diagnoses of complications. These have been listed as "Cause not given". (See Table VI). A study of these records reveals that many patients had temperatures of 100° to 101° late in their hospital term—on the 9th to 12th or 10th to 12th days. Since there were no concomitant symptoms or pathological manifestations and the patients were able to go home on the usual 13th day of their puerperium, this morbidity was of little or no significance. Another group included under this heading were patients who had morbidity following some degree of perineal laceration. Few, if any, had sloughing or break-down of the repair but all had sufficient reaction to cause a mild rise in temperature. It was apparent from our records that far more patients suffered febrile reaction with a lacerated perineum than did those on whom an episiotomy had been performed.

The number of days morbidity gives a better idea of the length of complications, the

patients' reaction to operations and the degree of their general health than does a mere statement of cause and percentage of morbidity. Analysis of the total days morbidity is shown in Table VII.

TABLE VII.

Days of Morbidity	No. of Cases	Total Days Morbidity	Morbidity % of Hospital Days	Aver. Days Morbidity per patient
2	337	674	0.52	
3	149	447	0.34	
4	60	240	0.18	
5	27	135	0.103	
6	8	48	0.03	
7	12	84	0.06	
8	3	24	0.018	
9	1	9	0.006	
10	3	30	0.02	
11	2	22	0.016	
12	1	12	0.009	
15	1	15	0.013	
18	1	18	0.014	
	605	1758	1.33	0.17

From these figures it will be seen that more than half of all our morbidity was of only 2 or 3 days duration. The average morbidity per patient is but 0.17 days.

Maternal mortality. Forty-one mothers died—a gross mortality rate of 0.41%. The causes of death are shown in the following Table:

TABLE VIII.

MATERNAL DEATHS.

Ruptured uterus		1
Eclampsia		10
Following Cesarean		6
Pulmonary embolus		3
Post-partum shock and/or hemorrhage		3
Uterine abscess with hemorrhage		1
Pneumonia with pyelitis and phlebitis		1
Septicemia following delivery		2
Ante-partum intestinal toxemia with resulting post-partum paralytic ileus and peritonitis		1
Peritonitis, streptococcus		1
Cause not given (1922 record)		1
Pneumonia during puerperium		2
Chronic myocarditis with		
Chronic asthma	1	
Pleurisy	1	
Toxemia	1	
	—	3
Pulmonary T. B. on admission		1
Pneumonia, on admission		2
Septicemia following streptococcus infection of face, present on admission		1
Fractured cervical vertebra		1
Meningitis on admission		1
		41

Of these deaths 9 are not of obstetrical origin or of labor sequelae. Two patients entered the hospital with a double lobar pneumonia, were delivered without an anesthetic and died of their pulmonary infection. One septicemia case entered with a massive infection of the face, delivered normally and died of a streptococcus septicemia. Another non-obstetrical death was that of an expectant mother who was in an automobile accident and sustained a fracture of the pelvis and of the cervical vertebrae with resulting total paralysis. She was near term and a section was performed to save the baby before the mother died. Others are the 3 cardiac cases, 1 with pulmonary tuberculosis and a case of meningitis. Deducting these gives an obstetrical mortality of 0.32 per cent.

Of the eclampsia deaths, it is interesting to note that 7 of the 10 occurred in the years 1921 to 1926 and only 3 in the succeeding 5 years.

Fetal mortality. Complete data for an accurate report on fetal deaths and still-births prior to 1926 were not available because of a change that year in the hospital method of chart recording and filing. During the last 5 years, 1927-31, there were 140 fetal deaths. The causes are shown below.

TABLE IX.

FETAL DEATHS.

(1927-1931)

Hemorrhage of Newborn	12
Spina bifida and hydrocephalus	6
Premature	86
Monstrosities	2
Deformities incompatible with life	6
Respiratory paralysis	4
Congenital heart	7
Jaundice neonatorum	4
Atelectasis	6
Pneumonia or pneumonitis	2
Following difficult labor (1 breech)	3
Pyloric stenosis	1
Toxic (?)	1
	140

Still-births. During the period for which data were available the causes of 162 still-births were as follows:

TABLE X.

STILL-BIRTHS

(1927-1931)

Cerebral hemorrhage	2
Delivered at home or in ambulance	2
Maternal toxemia (Eclampsia)	12
Following breech deliveries	16
Premature infants	29
Occiput posteriors (forceps)	2
Macerated fetus	26
Decapitation—large baby	1
Following difficult delivery (forceps)	15
Monstrosity	15
Unknown or cause not given	17
Following accidental hemorrhage	6
Following placenta previa	3
Prolapsed or constricted umbilical cord	11
Craniotomy	3
Atelectasis	1
Asphyxia—cord around neck	1
	162

Combining the fetal deaths and still-births gives a total "fetal loss" of 302 for the 5-year period, an incidence of about 1 in 20.

Because of changes in the personnel of the Pathological Department plus revised filing methods the record on autopsies is incomplete and not included in this report.

SUMMARY:

The report covers the Department of Obstetrics of an "open" hospital in which an average of 79 physicians care for maternity patients each year.

Thirty-one and three tenths per cent of the deliveries were abnormal, i. e., either forceps, breech (including versions for any reason) or Cesarean section.

Forceps were used in about 25% of cases.

Fetal mortality in breech cases is 11% for the entire series—for the years 1930 and 1931 it is 6.8%.

Cesarean Section was performed once in every 53 cases. Maternal mortality following the operation was 2.2%.

The maternal morbidity was 5.43%. The average daily morbidity per patient was 0.17 days.

Obstetrical mortality (maternal) was 0.32%.

Eclampsia accounted for more maternal deaths than any other single cause, 24.3% of the total. Ten patients died of eclampsia but only 3 during the past 5 years.

THE TREATMENT OF GOITRE

V. EARL JOHNSON, M.D., F.A.C.S.,
Atlantic City, N. J.

What different methods of treatment can we offer the Goitre sufferer? This communication is an attempt to compare and evaluate the use of x-rays or radium, the medical treatment, and the treatment by radical surgery.

Before attempting to discuss these various methods, I would state what is meant by the term goitre. I here have reference to those diseases of the thyroid which evidence themselves by the presence of uniform or nodular enlargements, either of which may be associated with or be without hyperthyroidism.

The classification recommended by the American Association for the Study of Goitre is probably the simplest of all. They recognize 4 types of clinical goitre in contradistinction to the many pathological classifications.

CLINICAL CLASSIFICATION

Nodular	Toxic
	Non-toxic
Smooth	Toxic
	Non-toxic

The smooth, uniform and symmetric goitre which occurs during adolescence in young girls is common in every physician's experience. This is the only type of goitre about which there is complete agreement regarding treatment. The treatment consists in giving small doses of iodine in the form of Lugol's solution or in the form of an iodide. Three to 5 drops of the solution may be administered daily in nervous cases, in the beginning, and gradually reduced to the same dose once every 2 weeks. The most important consideration in these cases is, they should be recognized and treated, but not overtreated.

Another point upon which there is complete agreement is that focal infections play an important rôle in goitre cases. Hayden reviewed 150 cases of hyperthyroidism at Crile's clinic. In 38 cases the active symptoms followed immediately after an acute in-

fection, mostly of the upper respiratory tract, and in most cases a diagnosis of influenza had been made by the attending physician. Other infections recorded included mastoiditis, phlebitis, dental sepsis, and enterocolitis. Tonsillitis (acute) is a frequent forerunner. Definite chronic focal infections were found in 85 cases or 57.6%.

In the group in which no chronic focal infection was present, no recurrence of hyperthyroidism was noted 2 years after thyroidectomy, while 7% of patients showing chronic focal infections developed recurrence and required a second operation.

Every patient with hyperthyroidism should be studied to discover whether or not chronic focal infection is present in teeth, tonsils, sinuses or the G. U. Tract. It is most unwise, however, to attempt to remove chronic foci before the hyperthyroidism is relieved. After thyroidectomy or the relief of the hyperthyroidism by other means, the foci should be removed or treated.

The after care of hyperthyroidism is not complete until focal infections have been adequately cared for.

There is apparently disagreement as to whether the elimination of the foci should precede or follow surgical treatment. Those who hope to cure a given case by means other than surgery have every justification for proceding to eradicate these foci as soon as the toxemia has been controlled. When, however, it is the intention to resort to surgery, the eradication of foci previous to operative resection seems to be "hitching the horse behind the cart". I understand that the preoperative elimination of these foci is recommended in an effort to place the patient in a better condition to withstand the operation. This would, of course, be ideal and would be approved by all surgeons; anything that can influence the recession of hyperthyroid activity is welcomed by surgeons. Hyperthyroidism is a disease, however, that must be handled with "kid-gloves", and one cannot take liberties in the performance of even such a trivial operation as the removal of an abscessed tooth. These cases are thrown into a thyroid-storm by even less than that. Most of us are familiar with the catastrophe which was reported almost 2 years ago, when a patient went into a thyroid storm and died following the injection of a varicose vein; this was a more simple procedure that the eradication of any type of focal infection. Furthermore, if a patient has been brought to a condition which will permit any type of operation, he is then in condition to withstand at least a partial, if not a total, resection of the gland.

X-Ray and Radium

Since their discovery, x-ray and radium have been frequently employed in the treatment of many diseases in order to avoid more radical procedures. There has been a constant race between surgery and these physical agents in the effort to cure certain diseases. On the one hand the surgeon claims that certain diseases belong to his domain, while the radiologists sets out to make the same claims. The limitations, however, of surgery have long been recognized as compared with the limitations of x-ray and radium therapy. It is well that the race for supremacy between these methods has occurred, for both branches of science have been advanced thereby.

In the treatment of goitre one must recognize at the outset that different forms of goitre are to be considered and that to a great extent the choice of treatment must rest upon the available skill obtainable regardless of which method is selected. Surgical skill is far more available that is that of a skilled and experienced radiologist; the latter is relatively rare.

At best the treatment of goitre by roentgen rays or radium is a slow process and inasmuch as published results of cases treated by these agents show a lower percentage of cured cases (75 to 80%) and a much higher mortality (5 to 10%), not from the positive effects of x-rays or radium, but from the slowness of control of the damage to other organs, it is the opinion of the great majority of authorities that surgical removal of the thyroid excess is, at the present time, the safer procedure in the aggregate. Recurrence after radium cure is about 15%, while after operation it is about 5%.

I believe that I will not be contradicted when I state that it is the consensus of opinion

among radiological authorities that none but toxic goitres should ever be treated by this method. In other words, the hyperplastic non-toxic goitre of adolescence, colloid non-toxic goitre and non-toxic adenoma should not be treated by these agents. The hyperplastic non-toxic goitre of adolescence is purely a physiologic goitre which is most successfully treated by small doses of iodine and more radical procedures are not indicated. The simple non-toxic colloid goitre is also more or less the result of a physiologic process not caused by disease of the thyroid itself. These cases are not benefited by radiation; in fact, the patient may be made worse. Non-toxic adenomatous goitres are progressively enlarging adenomas of the thyroid, and neither x-ray nor radium decreases the enlargement to any appreciable degree.

This leaves toxic adenomatous goitre and exophthalmic goitre as the only forms in which either of these agents has any justification. Control of the toxicity of adenomatous goitre by x-ray or radium is quite satisfactory, but it will not appreciably diminish the size of the adenoma. The greatest objection to the institution of these agents as the sole treatment in toxic adenomas is that in these cases the toxemia has been long existent and therefore the cardio-vascular damage and symptoms are pronounced and the delay in relief of the toxemia, occasioned by this slow method, allows additional damage.

It is in the treatment of hyperplastic or exophthalmic goitre that these physical means show their greatest value in the thyroid field. No one can deny that these cases are helped or even cured in this manner. The objections raised, however, are that while trying to cure a series of cases the number of deaths which will occur from the disease is too large, that the possibility of recurrence is 3 times as great as after thyroidectomy, and that the percentage of permanent cures is not as high as that attained by surgery.

What, therefore, should be the status of these agents in the armamentarium selected to treat a goitre patient? First, they should not be used except for toxic cases. Inasmuch as by far the majority of cases of toxic goitre can be put into shape for surgical procedures by rest, iodine, digitalis, high carbohydrate diet, hydrotherapy and ice bags, we have then only a small group of cases in which x-ray and radium seem to be indicated; these patients are all severely ill, do not react to the above treatment and may even become delirious or maniacal. X-ray should be called into service here because it does have the physical property of helping toxemia. Its use in other forms of toxemia seems superfluous and when used preoperatively, may even cause changes that will render the surgical operation more hazardous.

Medical Treatment vs. Surgical

Objections to operative treatment advanced by those who favor medical treatment are:

(1)	Risk of operation.	speaking of exophthalmic goitre
(2)	Hospital confinement.	
(3)	Disfiguring scar.	
(4)	Patient not cured by operation.	
(5)	Possibility of recurrence.	

The advocates of medical treatment have found increasing difficulty in supporting their contentions with actual proof and of late years they have been more concerned with advocating the use of x-ray and radium. Bram remarks "Let it not be understood that in Graves' disease surgical procedures are never indicated". He considers surgery indicated only when the goitre is causing pressure symptoms or when the gland is becoming malignant. Inasmuch as pressure and malignancy are never observed in exophthalmic goitre, it appears that Bram would not give the surgeons much to do.

One writer states that the field of activity of the internist is limited to the treatment of the toxic type—exophthalmic, hyperplastic and adenomatous—90% of which can be cured by methods other than surgical. The absurdity of such statements is evident from the fact that the first 2 types he mentions are one and the same, and from the fact that there is no medical treatment known to science capable of curing adenomas in any part of the body.

The answer, in brief, to the objections of-

fered by medical advocates of the treatment of exophthalmic goitre, is as follows:

(1) The risk of operation at the large goitre clinics is between 0 and 1%.

The medical mortality ranges from 10 to 25%.

Death is not the only tragedy in Graves' disease. Many patients undergoing medical treatment survive one or more crises only to suffer extreme ulcerating exophthalmos, chronic passive congestion of the liver, nephritis and psychoses, until death occurs from cardiac decompensation.

(2) The period of hospital confinement is at the greatest about 2 weeks. Patients under medical treatment, with marked symptoms, will spend a much longer period of confinement either at home or in the hospital and most of these have relapses and are then fortunate if operation is urged. Also those cases that have been treated medically until marked cardiac decompensation or marked emaciation has occurred will necessarily require more than the 2-weeks-stay under surgical management.

Bram advocates rest for 16 hours a day for many months or a year, suggesting that the time be spent in pleasing occupations, such as listening to music, reading light literature or engaging in light games. For the majority of people, who are dependent on their own exertions for a livelihood, this practically amounts to economic suicide.

Kessel and Lieb insist on confinement for 3 months or more.

(3) Scar on neck? Experienced goitre surgeons find that their patients are not nearly as much concerned about a scar on the neck as about one on the heart. They can cover up the worst scars, but fine raiment will not conceal the evidence of cardiac decompensation, emaciation or extreme exophthalmos.

As as matter of fact, the surgical technique has improved to the extent that the scar from thyroidectomy is not objectionable, even to the most fastidious. Certainly no one would argue that the fine hair-like scar is more objectionable than a disfiguring goitre, or an x-ray or radium burn.

(4) Patients not cured by the operation? In 1920, Judd of the Mayo clinic made a study and found that 80% had remained cured 6 years after operation and that more than 5% of the remaining were improved. These patients were operated on before the advent of the more recent surgical advances which have made possible a technically more perfect operation.

Crile states that 90% of exophthalmic cases are cured by operation. Those that recur can be blamed on 2 things—(1) technical faults, such as insufficient removal of the hyperplastic tissue, or leaving the isthmus, or ligating a mass of goitrous tissue with the superior artery or not removing the upward extension of the pyramidal lobe when present. These should and must be eliminated by the goitre surgeon; (2) those cases having what he terms goitre diatheses, which cannot be cured by operation, x-ray or radium, or rest and medication. Those cases are the ones he selects for adrenal ennervation.

(5) The actual rate of recurrence today can be kept as low as 1 to 2%. Speed is no longer such an important factor and it is now possible to take time to remove almost the entire gland.

Plummer states that exophthalmic goitre disease progresses in a series of waves, and that at the crest of the waves the symptoms are intensified and a crisis occurs. Following the crisis there is a period of remission of variable length, during which the hyperthyroidism subsides. After some weeks or months this is repeated. One or several such attacks may occur, and the patient may survive one or all of them. Even though he survives these attacks, however, the patient is constantly incurring a serious permanent damage to his cardio-renal-vascular system and nervous system that results in either chronic invalidism or death. While exophthalmic goitre has a much more rapid onset and causes a more striking change in physical appearance than does the type occurring in toxic adenoma, there is less permanent disability in the patient who receives early surgical attention. In the early months of the disease the heart may become acutely dilated, but it does not suffer the severe myocardial damage that occurs with toxic adenoma. Let the patient with exophthalmic goitre continue

under symptomatic treatment for a year or more, however, and damage is done that cannot be remedied by thyroidectomy or any other means.

Compare the medical régime, with its long period of treatment in the home or in the hospital, or sanitarium and its restriction of activity, and diet, with the surgical régime now in vogue.

With the valued coöperation of the able internist who appreciates the importance of early surgical intervention, patients with exophthalmic goitre are restored to normal health within a few weeks of the onset of the disease.

Other Operations Upon the Goitre Patient

Focal infection: We have already dealt with this phase.

We here refer particularly to the performance of elective operations, such as those on the gall-bladder, the pelvis, etc., in patients who simultaneously have goitre. If the patient has any of the types of non-toxic goitre, which are not causing pressure symptoms, the thyroid may be disregarded and the proposed operation proceeded with. On the other hand, if the goitre is toxic, even if mild, the removal of the thyroid should precede the other operation. Andrews (Chicago) reports the following case:

This patient was suffering from gall-stones and duodenal ulcer. It was noted also that her pulse suddenly became rapid and went up on occasions to 115 to 120, although it was frequently found in the 70's. A basal metabolism test showed a reading of +20, which under medication was brought down to +13. He decided to do the abdominal work in spite of this knowledge. During the following 36 hours his patient went into the most terrific thyrotoxic reaction he had ever seen. The pulse became wildly irregular, too fast to count, and the temperature rose to 106° F., patient had a mild delirium for 2 days and had diarrhea, sweating and tremor. Fortunately, after a very stormy course, the patient recovered. The goitre was removed at a later date.

He states that it is interesting to note that this patient had previously been operated upon twice. One operation was a tonsillectomy and the other a perineal repair. Following both of these she had very similar attacks of thyrotoxicosis.

Not quite a year ago, I was asked to see a patient who had a pelvic operation consisting of a D. & C., and removal of both tubes, right ovary and appendix, and who was supposed to have developed secondary post-operative hemorrhage the evening of the same day. The pulse suddenly went up from 98 to 140, the patient felt very weak, was vomiting and was very nervous. Examination showed no evidence of hemorrhage, except the rapid pulse, but a moderately enlarged nodular thyroid was found, and the patient stated that she had had toxic spells from her thyroid. Hydrotherapy, intravenous glucose and sedation brought her through this moderate thyrotoxic crisis. Lugol's solution was then given over a period of a few days.

Pregnancy and Goitre

Another interesting situation presents itself when a patient suffering from hyperthyroidism becomes pregnant. The question arises as to the best manner of handling these cases. There are 3 possible approaches to the treatment:

(1) Therapeutic abortion.

(2) Operation in spite of pregnancy.

(3) Medical treatment during the period of gestation, delivery of child and then further treatment of the thyroid.

The question of therapeutic abortion is mentioned only to be absolutely condemned. There is no possible excuse for it, because if the patient can stand the operation to produce the abortion, then the patient could just as well have stood an operation on the thyroid gland.

Last May a patient consulted me complaining of extreme nervousness, dyspnea, swelling of both ankles, cardiac palpitation and loss of weight. Examination disclosed a bilateral enlargement of the thyroid, staring eyes, tremors of face, lips, tongue and hands, pretibial edema, pulse rate 122, blood pressure

135/80, inability to step onto a low stool, purposeless movements and incurvature of the fingers. She had not menstruated for 3 months and vaginal examination revealed pregnancy.

I proposed and strongly advised that a thyroidectomy should be done without delay. It was my opinion that the hyperthyroidism would be made worse as time went on and that by the time she came to term it was doubtful whether she could withstand the added strain of labor. She accepted my advice and was ready to go to the hospital when some friend insisted that she consult one of our well known Philadelphia surgeons. She did this, and she was advised not to be operated upon, but to arrange to get x-ray treatment. She was also advised to continue taking the Lugol's solution which had already been prescribed. When she presented herself for x-ray treatment to the radiologist she had improved so much that he questioned the advisability of giving her treatments and, in fact, only gave two treatments. She went on to term, taking Lugol's solution 5 to 10 drops 3 times daily, and delivered a full term baby without any difficulties. The baby could not be made to breathe, but as the heart was beating it was placed in the respirator. The heart continued to beat for one hour but the baby never did breathe. One questions what influence the thyrotoxicosis, the iodine or the x-rays, either individually or combined, had on the death of the baby.

This patient, fortunately, withstood the strain of labor, but is now convinced that she can cure herself with iodine and is proceeding to do so without medical advice.

Crile has tried (1) induction of abortion, (2) waiting for delivery and (3) operation during pregnancy. He is in favor of operation regardless of the stage of pregnancy. He has tried interruption of pregnancy and allowing patient, under treatment, to go to labor, but now favors operation.

Iodine in Goitre Treatment

Iodine, in one of different forms, is by far the most useful, and at the same time the most abused, preparation at our command in the management of these cases. It should only be used as a curative agent in the colloid types of goitre. It should never be used as a cure for any other type of goitre. The place for iodine in the toxic goitres (toxic adenoma and hyperplastic or Graves form of goitre) is in the preparation of those patients for operation. One should resist the temptation to give it merely for symptomatic relief.

When a patient has definitely submitted to operation, then and then only should iodine be prescribed, so that when the greatest possible improvement has been obtained, operation may be performed without further delay. Improvement may practically always be obtained once with iodine, but after that one can never be sure that it will give the same relief again and thus the patient will be cheated of that amount of chance of cure or even survival at operation.

Summary

(1) We have shown that x-ray or radium cures 70 to 90% of toxic thyroid disease; that the mortality from the disease, while under this treatment, is about 15%, that about 15% of cases recur; that adenomas cannot be cured by this method.

(2) We have tried to show that the medical régime is economically out of the question for the large majority of cases and we question the percentage of permanent cures. We have revealed that the mortality from the disease while under medical treatment ranges between 10 and 25%.

(3) We have stated that radical surgery carries by far the lowest mortality rate, being only about 0.5 to 1%; that recurrence occurs in only about 10% of cases; and that 85 to 90% are permanently cured. Radical surgery also gives the shortest period of morbidity.

Public Relations

HOW DO WE GET A COLD?*

Wells P. Eagleton, M.D.,
Newark, N. J.

Do we catch a cold, or do we *get* a cold? Do we catch it as we do scarlet fever or smallpox, from another person, from contact with germs outside ourselves, or do we *get* a cold from something *within* ourselves? The answer is that both are true *in part*. We *can* catch a cold from another, but the vast majority of common colds come from something within ourselves. For if we are well, and not tired, and have no disease in our throat or sinuses, germs do not give us a cold, for the germs are there all the time.

Germs which are found in all cases of colds can be placed in the normal sinus of an animal and the animal refuses to be sick, for the nose contains a delicate mechanism that washes everything away. It produces mucus that catches the germs in it and prevents them from injuring the tissues. If, however, you take certain germs that are always present in our throat and make them *very* virulent by *artificial* means and *then* plant them in the mucous membrane, the animal soon dies.

What is it, then, that makes us take cold? If we don't catch it, what gives us a cold?

The answer is, an imperfect equilibrium.

For illustration: It is a *raw* day. A man is tired. He has not slept the night before. He goes into a subway train, where the sun never shines. At every station the doors are opened and there is a draft through the train. He has traveled in this train every night for a whole winter without harm, but tonight he feels drowsy and is annoyed by the draft on his feet. The next morning he awakens with a cold.

Three factors, then: a raw day, a changing temperature and a tired man. What has happened? *A sudden change of the equilibrium of fluids at a time of poor resistance.*

What is meant by equilibrium of fluids? It means life. It is equilibrium of the fluids that draws the sap in the tree from the ground up to the farthest leaf. The same thing happens in the human body. This process goes on all the time. As much fluid is supplied to each cell as is necessary for its proper functioning. We call these fluids colloids. How they are created by life, nobody knows. But for continuation of health the equilibrium between these colloids must be exact.

One of the chief functions of the body which has to do with equalizing sudden changes, is sweating.

If I take a glass of water and put a piece of ice in it, and it is a warm day with a high humidity, the glass sweats. Something has happened between the *water* in the air, and the *ice water* in the glass which has caused the water in the air *to settle* on the outside of the glass.

Sweating is a very important function for the preservation of our health. In some of the eastern countries a literal translation of the ordinary salutation is—do you *perspire* freely? For, in a *hot* climate, if a person is perspiring, he is in good health.

If you place a man in a tightly closed glass compartment without any ventilation, he breaks out in a profuse sweat and in a very short time he becomes unconscious. But if you place over the man an electric fan and so cause the air to circulate, he can remain in that compartment a comparatively long time with perfect comfort.

Thus, there are *3* factors in our environment that influence our comfort—and when we are comfortable we do not catch cold; viz., temperature, humidity and air movement. Great differences in one factor are overcome by the other factors, but a combination of differences in all factors may make a great difference in our comfort. I have been spending the summer at the North Shore. One day the temperature was 72°. There was an east wind blowing. The humidity was over 90, and I felt cold and clammy. Another day the temperature was also 72. There was a gentle breeze blowing, but the humidity was low, and I said "It is just like a fine day in Ocotber" and I could work. Still another day the temperature was 78. There was no wind. It was still and muggy and the humidity was nearly 100. I felt hot and prostrated. I could not work.

Now, if during a great change in environment our resistance is low, we may take cold, and these 2 factors, germs and disturbed equilibrium, are intimately related; as the frequency of pneumonia runs parallel to the frequency of colds in the nose and of sore throat.

For now we know that certain types of pneumonia are contagious and the germs of pneumonia are carried by individuals just as typhoid is carried by typhoid carriers. In one institution of over 100 individuals, pneumococci were found in the throats of all, and 2

*(Radio talk given over the Yankee Network, September 21, 1933, during the meeting at Boston of the American Academy of Ophthalmology and Otolaryngology.)

of the inmates were found to be carriers; but that did not mean that all the others had pneumonia, although they all had the germs of pneumonia in their throats.

Warm air, and therefore, a warm climate, play an important part in our susceptibility to colds. The year that I was in Bombay there was not a single case of mastoid disease. There are practically no nose and throat clinics in India, because it is warm, although many of the natives are so poor that they sleep in the streets.

Another factor in the *prevention* of cold is breathing through the nose. If you find that you cannot run and keep your mouth closed, you have some form of nasal obstruction. Partial nasal obstruction is more common than is realized.

Dr. William Emerson, of this city (Boston), examined over 600 people in apparently perfect health and found that 25% of them had partial nasal obstruction. So, if you cannot run and still breathe through your nose, you should consult a specialist.

What can a cold do to your ears? It is the same question of an upset equilibrium between the tissues and the environment. But, now, it upsets conditions in barometric pressure. When you go through a tunnel in a train you have to swallow several times to relieve the *full feeling* in your ears. The atmospheric pressure in the tunnel is different from that outside. The same thing happens when you have a cold or when you have nasal obstruction. It interferes with the delicate equilibrium in the ear and continued disturbance gives rise to *gradual* deafness. Of course, when we have an infection and active germs pass into the ears, they give us earache, running ears, mastoiditis, and even meningitis. For there are little passages that run from our ears into our brain, and if the ears are infected we may develop meningitis, or inflammation of the brain. This is curiously illustrated in the case of rodents. There is an open space between a rodent's ears and its brain and when an infection occurs in a rat's ear it dies from meningitis, a disease which kills rats by thousands.

The danger of brain infection from neglected colds is greatly underestimated, for every year there is a large number of cases of meningitis which have started with a cold apparently so slight that the patient did not even remain in the house.

Epidemic sleeping sickness may also begin with a cold in the nose and there is no doubt that the poison that causes it, is absorbed from the mucous membrane.

Impaired nasal breathing interferes with the proper functioning of the brain. See what the operation for the removal of diseased tonsils and adenoids does to the growing child. It often transforms a backward child to an alert, bright one.

It is all a question of how to live, and here is where the family physician comes in. He will not fail you. The great trouble is that people go to the family physician only when they are really sick. They should also go to him while they are well.

The longer I live, the prouder I am of being a doctor. In this day of change the only ones who have not undergone a change in *spirit* are the creators, be they creators of art, literature or of medicine. All others are unsettled. Our financial system is undermined. Statesmanship has failed, for today all nations are again building great armaments. The formerly worshipped captains of industry are now regulated by the Government. The only 3 professions whose *methods* have not changed are the clergy of all denominations and all creeds who have been honestly trying to better the spirit of Man; the teachers of *all grades and all kinds* who have been sincerely trying to improve the mind of Man; and the medical profession, which in spite of all its detractors from within and without, has been honestly trying to make men stronger and healthier. On their banner it is still written—"What we have striven to be, but are not, that are we worth to God."

School Health Department

Allen G. Ireland, M.D., Medical Director,
State Department of Public Instruction,
Trenton, N. J.

Football! Injuries! After-effect! The foremost preventive of football is conditioning. When the muscles are firm and responsive, the nerves steady and alert, and the body rid of poisons, the chance of injury is slight. All good coaches know this truth. To many, prime condition is a religion. Others are careless, and their boys pay the penalty. School physicians can help. While not able to give the time for daily supervision, they can keep in touch with the coach, who will appreciate your advice. Look over the squad occasionally. Encourage the coach to confide in you.

Interesting question from a school physician: "Where may I obtain information concerning sex education in the school?" Answer: American Social Hygiene Association, 450 Seventh Avenue, New York City, New York.

Objectives for the Physician

It is not practicable to set forth objectives for all schools. Local circumstances will govern the ultimate selection of goals. It is sufficient here to suggest those common to many school systems.

(1) To establish a program of activities that will best utilize the talent of the physician.

(2) To assist the school administrator with the hygienic and sanitary maintenance of school buildings: by holding regular inspections, by reporting conditions and making the necessary recommendations for their correction, and by suggesting a code of instructions covering the duties of janitors.

(3) To advise teachers regarding the application of the laws of hygiene to the management of the classroom and to the teaching process.

(4) To assist the school administrator in devising a code of rules and procedures pertaining to the prevention and control of communicable disease.

(5) To establish a program of examinations and inspections designed to inventory the health needs of the pupils.

(6) To devise with the assistance of the school administrator a system for bringing the pupil health needs to the attention of parents, family physicians and dentists, and teachers.

(7) To determine with the school administrator what policy to adopt concerning correction and treatment under school auspices.

(8) To coöperate with teachers, heads of departments, and supervisors in providing special health programs for selected cases.

(9) To direct the professional work of the school nurse.

School Hygiene

Sanitation and hygiene of the environment are branches of medical science, and, although the educator has studied them from the school angle, it is the place for bringing the knowledge of the physician to bear upon an important educational factor. It is educational in that the type of school environment to which the pupil becomes habituated may determine standards and ideals by which he later creates a home of his own. It is protective in so far as sanitation and hygiene prevent disease.

Parents' Meetings

Organized meetings for parents hold great possibilities and, in some communities, they are very popular. They must be made practical and interesting. An occasional guest physician such as a psychiatrist or a pediatrician will often attract an audience.

The meetings may be general in character, open to all parents, or small conferences may be tried to which the mothers of pupils with like defects are invited. One month for example, malnutrition would be the topic; another month, defective vision and care of the eyes; again, the nervous child.

Meeting the Teachers

The physician's knowledge should be available to principals and teachers. Through carefully prepared talks he can convey valuable information relative to the following: personal hygiene for the teacher; findings of the health examination; school hygiene and sanitation; conservation of vision; signs and symptoms of communicable disease; simple first aid measures; heating and ventilation; essentails of mental hygiene; seating and posture; recognition and treatment of malnutrition; recognition and care of the tired child; the nervous child.

The School Lunch

A pamphlet called "The School Lunch" is available. Address requests to Dr. A. G Ireland, New Jersey State Department of Public Instruction. Trenton, New Jersey.

State Health Department

J. Lynn Mahaffey, M.D.,
Director, State Department of Health

Trachoma, a contagious disease of the eye, affecting the inner surfaces of the lids, has proved to be a stubborn disease to overcome.

A year ago, some 90 cases of trachoma were found in a group of children in an institution in this State. These were all treated and most of them were considered cured. However, examination of these children in recent months revealed more than 40 cases still showing signs of the disease.

Most boards of health have coöperated promptly and intelligently in securing examination of suspected cases and contacts and in restricting those found to be affected. If neglected, trachoma is likely to cause prolonged suffering and eventually may lead to blindness. If properly treated in time, it may be cured or arrested. Recent investigations have shown the disease to be much more prevalent in New Jersey than was thought to be the case. It has been found both in city and in rural districts.

The early signs of trachoma usually are smarting and watering of the eyes, a roughness of the inner surface of the lids giving a sensation of particles in the eye, and granulated eyelids. However, all these symptoms may not be present and the eye itself may appear normal until the lids are examined.

Trachoma is easily confused with other, less serious eye conditions and expert medical examination is usually needed to identify the disease in its early stages.

Discharges from eyes affected with trachoma spread the disease to other persons. Such discharges may reach the eyes of others by the use of towels, washcloths, wash basins, handkerchiefs or pillow cases which have previously been used by a person having trachoma. The disease may also be spread by fingers or by anything that comes in contact with the eyes of an affected person. Therefore, whatever is likely to be infected by a case of trachoma should not be used by another person until it has been boiled or otherwise disinfected.

Trachoma often develops slowly and may be slow to cure. Persons having suspicious symptoms should secure expert medical attention without delay and, if found to have trachoma, should continue treatment as long as may be necessary.

OFFICIAL MORTALITY RATES

J. Lynn Mahaffey, M.D.,
Director of Public Health, State House,
Trenton, N. J.

New Jersey has good reason to be proud of its health record for 1932, when new low general and infant mortality rates were attained for the year. The general death rate for 1932, 10.11 per 1000 population, was the lowest rate since the State Department of Health was established 55 years ago; the previous *recorded low* having been 10.63, for both 1930 and 1931.

The death rates from typhoid fever, diphtheria and tuberculosis were all the lowest rates for those diseases ever reached in the State of New Jersey; typhoid, 0.7 per 100,000 population; diphtheria, 2.2; and tuberculosis, 60.6.

The *maximum* typhoid fever death rate in New

Jersey occurred in 1882, when the rate was 74.3. Since 1912 the annual death rate for this disease has not exceeded 10 deaths per 100,000 population, and the highest during the past 5 years was 1.7 in 1928.

The death rate from diphtheria for 1888 was 148 per 100,000 population. During the decade beginning with 1900 the rate declined from 48 to 25; the following 10-year period showed a decline to 18; and for 1932 it was the lowest yet recorded.

The death rate from all forms of tuberculosis was 60.6 per 100,000 population, which compared favorably with a rate of 90.1 from the same disease only 8 years ago.

The death rate from cancer and other malignant tumors was 113.1. The death rate from this cause has gradually increased from 37 per 100,000 population in 1879.

Approximately 62,250 births were reported as occurring in 1932; which was equivalent to a rate of 14.6 per 1000 inhabitants; but the total births reported showed a decline of approximately 2000 from the number recorded for 1931.

The infant mortality rate under 1 year of age, per 1000 babies born alive was 49.6, which is the lowest in New Jersey since such rates were first published, in 1906. The number of mothers who died as a result of child-birth, was 361 or 5.7 per 1000 babies born alive. This compared with 5.9 for the preceding year.

Deaths due to accidents in which moving automobiles were involved totaled 1158, as compared with 1302 in 1931; figures which include 10 deaths due to motorcycle accidents and 19 deaths of bicyclists who were struck by automobiles, but they are exclusive of 35 accidental deaths due to the inhalation of motor exhaust fumes.

Analyzed, the motor fatality records show the death of 620 pedestrians; which number is equivalent to 53% of the total. More than ¼ of the pedestrians who died were children under 15 years of age. Of the drivers and occupants of automobiles who were killed, 16% were less than 20 years of age.

Current Events

MINUTES OF BOARD OF DIRECTORS MEETING, NEW JERSEY TUBERCULOSIS LEAGUE, INC.

Thursday, October 19, 1933, Stacy-Trent Hotel, Trenton, N. J., at 4.30 P. M.

Those present were: Dr. Collier, Chairman; Dr. Abell, Miss Allen, Dr. Crankshaw, Mrs. Dell, Mrs. DuBois, Commissioner Ellis, Dr. English, Mr. Garver, Mrs. Geckle, Dr. Hatch, Mr. Hopkins, Dr. Ireland, Mr. Kinkead, Dr. Morrison, Dr. Morrow, Dr. Newcomb, Dr. Pollak, Dr. Potter, Miss Palmer-Quinby, Mrs. Quinn, Dr. Raycroft, Dr. Runnells, Mrs. Shreve, Dr. Silk, Miss Walker, Dr. Wilkes and the Secretary. The following attended the Annual Meeting but did not remain for the Board Meeting: Dr. Fish, Dr. Harman, Mrs. Kingston, Mrs. Little, Dr. Mahaffey and Mrs. Terhune. Regrets were received from: Miss Butters, Dr. Gluckman and Mr. Merrell.

As the minutes of the preceding meeting had been sent to members, the reading of them was dispensed with.

A brief report of the Staff was presented and placed on file.

The Treasurer's statement to date was presented by Mr. Kinkead and placed on file. Total receipts from the 1932 Seal Sale amounted to $199,136.76. Percentage has not been paid on $15,964.85 as follows: Atlantic, $4,941.37; Middlesex, $1,329.37; Passaic, $9,694.11. The question whether we should accept preferred bank stock from Middlesex and Atlantic Counties in payment of Seal Sale percentage was referred to the Finance and Budget Committee.

The tentative budget for 1934, the same as 1933, was approved.

The loan from $300 to $500 to Warren County was approved, but on advice of Dr. English, who stated that Warren County had received some unexpected funds and would not need this for the time being, the Secretary was asked to hold it up until a further request was received.

The report of the Nominating Committee for Board members at the Annual Meeting, as well as for officers and the Executive Committee, was presented by Dr. Hatch. On motion of Dr. Morrow, seconded by Dr. Silk, the report of the committee was accepted, and the Secretary was requested to cast 1 ballot for those names.

The report of the Committee on Examination of School Children was presented by Dr. Pollak in the form of Resolutions, which, on motion of Dr. Pollak, seconded by Dr. Silk, were adopted:

Whereas, in spite of the ever-decreasing death rate from pulmonary tuberculosis, the incidence of tuberculous disease among the teen age group, particularly among young women, is steadily increasing, causing about 70 to 80% of the total deaths from tuberculosis; and,

Whereas, the studies carried on through the initiative of the National Tuberculosis Association by various specialists throughout the country, notably Chadwick, of Massachusetts; Hetherington, of Philadelphia; Myers, of Minnesota; Edwards, of Connecticut; Rathburn, of Chautauqua County, New York; and by the Staff of the Hudson County Tuberculosis Clinics, and more recently by the more exhaustive studies of English, of Glen Gardner, and latterly supplemented by the studies carried on by Ireland, of the State Department of Education, and others, have pointed out through surveys conducted by them by means of tuberculin testing and follow-up by x-ray that a large number of unsuspected cases of adult and a larger number of childhood-type tuberculosis have been discovered among junior and high school students; and,

Whereas, this method of follow-up is the most cogent recognized method of systematically and scientifically attacking the tuberculosis problem at the earliest possible moment;

Be it resolved, that the physicians of the New Jersey Tuberculosis League in meeting assembled to study this problem hereby recommend that it be the policy of the New Jersey Tuberculosis League to foster, advocate and stimulate a program which shall in scope and effect meet this situation along similar lines as the Shick test has met its most critical antagonists; and,

Be it further resolved, that these resolutions be submitted to the Committee on Public Health of the New Jersey State Medical Society and the respective component county medical societies so that this plan may be incorporated in the well-rounded-out program adopted by the New Jersey Medical Society; and,

Be it further resolved, that the physicians identified with the tuberculosis institutions hereby tender their services to the several committees on public health of the respective medical societies

throughout the State and offer all available facilities within their institution; and,

Be it further resolved, that upon the acceptance of the plan by organized medicine within the State that it shall be the outstanding policy of the New Jersey Tuberculosis League through the medium of its various departments to assist in this propaganda of education and to offer such available financial support as may accrue through the annual Seal Sale of the New Jersey Tuberculosis League which shall have been budgeted for this purpose; and,

Be it further resolved, that the respective services of the various county leagues as well as the State Tuberculosis League, otherwise provided for in the budget, shall in no way be affected by such contribution; and,

Be it further resolved, that by the acceptance of this program by the aforesaid medical societies, tuberculin testing of children of the teen age group shall be the outstanding policy of the New Jersey Tuberculosis League to the end that tuberculosis within the ranks of the youth of our State shall be effectively controlled.

Dr. Ireland stated that these Resolutions seemed to be satisfactory. Some question was raised as to how these Resolutions could be put into effect. Dr. Wilkes stated that if a copy of the Resolutions were sent to him, they would be presented to the Public Health Committee of the Medical Society of New Jersey, and then forwarded to the various county medical societies, and that it would be advisable for each local association not to take any action or give any publicity to these Resolutions until the county medical societies had passed on them. Dr. Morrison stated that if a copy of the Resolutions was sent to him, he would see that they were printed in the Journal of the Medical Society of New Jersey.

On motion of Dr. Silk, seconded by Mr. Garver, the recommendation of Dr. Emlen Darlington, of Burlington County, at the medical session held at Glen Gardner Sanatorium, that we go on record in favor of preserving the medical and nursing service in the schools of the State, was approved. Dr. Ireland pointed out that this service had been jeopardized in many localities and State appropriations may be withheld where this service is discontinued. He suggested that we send this Resolution to him for further action.

Dr. English gave a report on collapse therapy clinics, stating that he hoped to inaugurate clinics in various localities with the approval of the County Medical Societies to meet a real need for those patients having received treatment at Glen Gardner who have no facilities in their home town for further pneumothorax treatments. On motion of Dr. Morrison, seconded by Dr. Silk, this plan was referred to the Executive Committee for approval.

On motion of Mr. Kinkead, the next meeting of the Executive Committee was set for December 6.

Book Review

THE TECHNIC OF LOCAL ANESTHESIA, by Arthur E. Hertzler, A.M., M.D., Ph.D., L.L.D., F.A.C.S., Professor of Surgery in the University of Kansas. Cloth. Fifth Edition. Price $5. Pp. 292, with 148 illustrations. St. Louis: C. V. Mosby Co. 1933.

Hertzler's book is too well known to require much praise. The present edition is in every way up to the high standard of its predecessors and in a number of ways maintains the steady improvement which each edition has shown over the last.

It has successfully accomplished the purpose of the author, "to show not what operations can be done under local anesthesia, but which can best be so done". It is brief, clear and concise, and in a small book gives the reader most of the important methods of local anesthesia. It does, however, omit the more recent advances in the anesthesia of the surgery of the nasal accessory sinuses. There are timely but brief chapters on spinal anesthesia and intravenous anesthesia. The illustrations are abundant and unsurpassable for their clearness and instructiveness.

This book should be of interest to every practicing physician and should have a place in the library of those who are interested in general surgery.—J. A. M.

Woman's Auxiliary

A LETTER FROM THE PRESIDENT

October 16, 1933.

To the Members of the Woman's Auxiliary to the Medical Society of New Jersey:

With wishes that this will be a successful, happy year for all of you, I greet you and express my appreciation of the honor you have bestowed upon me. I thank you for the privilege of representing you at Milwaukee and have come home filled with enthusiasm for the work before me. I want to inspire you to make this the best Auxiliary year we have ever had. The letters I have received from Mrs. James Blake, our National President, are so inspiring I want to pass on to our county Presidents some of her messages. I shall add any suggestions brought to my attention or which I may think of that will be helpful, to the messages which I plan to have in this column frequently.

Some of the suggestions in Mrs. Blake's letter are as follows:

"To all State Presidents and their committee chairmen, and to every County President and every county committee chairman: I wish you at all times to remember that the County is the unit of our work; service to the men in our individual counties, our keynote. The Advisory Board from the County Medical Society is our helpmate in every way.

Sane planning of programs and sane expenditure of money are the duties of every County President and her Executive Board. Each county should find and stress one thing if possible. Always remember we aim to back every worthwhile and authentic health project or agency in a County; always remember that each group must *lead*, not be *led*. So, be *leaders* under the advice of your Advisory Council, in every community project.

Read your husband's State Medical Journals to keep in touch with the problems of the medical profession. Only by a monthly perusal of an authentic medical magazine can you hope to keep your mind in condition to do a concrete, helpful piece of Auxiliary work.

For the mutual benefit of every one on your membership list, let the Press and Publicity Department have your choice bits of work, your plans and accomplishments. 'Ask and you shall receive' are familiar words. I wish to add to them, 'Help and you shall be helped.'

Everybody should make Hygeia a regular monthly diet. You just cannot exist in an Auxiliary way

without it. And your influence in urging its use in any and every conceivable way by the lay public will repay you and yours a hundred ways.

It seems rather unnecessary to remark that the organization work must be continued—so that many of our States may be reported with a full membership."

The next meeting of the Woman's Auxiliary to the Medical Society of New Jersey will be held in Trenton on Monday, January 8, 1934. Please plan to have a large number from each county attend this meeting and luncheon. It will be an open meeting for every County Auxiliary member as well as for the County and State officers and chairmen. The Committee in charge of the arrangements for the meeting would appreciate your early response and remittance when you receive their notice for it.

(Mrs. Harry V.) Viola B. Hubbard.

Atlantic County

Anna M. Mally, Corresponding Secretary

The first regular meeting of the Fall season of the Woman's Auxiliary to the Atlantic County Medical Society was held on Friday, October 13, at 8 o'clock, at the Chalfonte Hotel. Mrs. Joseph Poland presided. It was decided, after much discussion, to hold meetings afternoons and evenings, alternately so that all members could attend at their convenience.

Standing committees for the year were appointed as follows: Mrs. Carl Surran, Membership; Mrs. Edwin H. Harvey, Courtesy; Mrs. Daniel Reyner, Entertainment; Mrs. James North, Hygeia; Mrs. James H. Mason, Program, and Mrs. Samuel Salasin, Publicity.

A small sum will be set aside each month to provide milk for 1 or 2 families during the Winter. A donation of $10 was sent to the Pleasantville Branch of the Red Cross.

An interesting program for the season has been promised and all members are urged to attend meetings.

Union County

Mrs. George Seymour, Reporter

A regular meeting of the Woman's Auxiliary to the Union County Medical Society was held in the Nurses' Home of the Elizabeth General Hospital on October 11, Mrs. Harry Bowles presiding.

Dr. Edward J. Ill, of Newark, as guest speaker, gave a résumé of the work being done by the Society for the Relief of Widows and Orphans of Medical Men of New Jersey.

The Secretary's and Treasurer's reports were accepted as read. Plans for welfare work were discussed.

Mrs. Harry V. Hubbard, State President, gave a very interesting report on the National Convention of the Woman's Auxiliary held in Milwaukee during the month of June.

The Executive Board had previously met at the home of the President and planned to institute a Scholarship Fund. The plan was presented to the Auxiliary for consideration and was unanimously approved.

The first of a series of card parties will be held at the home of Mrs. Harry Bowles in Summit on November 14, the proceeds of which will be turned over to the Scholarship Fund.

Upon motion, the meeting adjourned.

County Society Reports

TRI-COUNTY MEDICAL SOCIETY

(Morris, Sussex and Warren)

Reported by Dr. Marcus A. Curry

The Annual Meeting of the Tri-County Medical Society was held during the morning and afternoon of Tuesday, October 10, 1933, from 11 o'clock to 3:30, at the New Jersey State Hospital at Greystone Park.

President F. Grendon Reed, of Mountain Lakes, presided. There was an attendance of some 35 members and guests; the latter including First District Councilor Christopher C. Beling, of Newark. The guests were cordially invited to participate in the meeting with the members.

After calling the meeting to order, the President read a telegram from First Vice-President L. W. Hackett, of Washington, stating that illness prevented Secretary Charles B. Smith from being present and the Secretary's illness prevented Dr. Hackett from being present. A telegram of sympathy and encouragement was dispatched to Dr. Smith and the sentiment of the members was also unanimously expressed by voting that flowers be sent to the Secretary.

Dr. Lawrence H. Bloom, of Phillipsburg, was appointed Secretary pro tem and ably performed the secretarial duties.

Routine business included the reading and approval of the minutes of the 1932 meeting and also the Treasurer's report, which showed a balance on hand of $297.76, exclusive of bills ordered paid at this meeting and dues received.

Five new members were unanimously elected; these comprising Herman Baldauf, Belvidere; Marcus A. Curry, Greystone Park; Arthur G. Lane, Greystone Park; Raymond J. Harquail, Greystone Park; and George W. Comeau, Morris Plains.

Election of officers for the ensuing year resulted as follows: President, L. W. Hackett, Washington; First Vice-President, F. H. Morrison, Newton; Second Vice-President, Byron G. Sherman, Morristown; Secretary, Charles B. Smith, Washington; Treasurer, Ervin McElroy, Rockaway; Executive Committee, J. G. Coleman, W. A. McMurtrie and H. B. Bossard; Finance Committee, A. C. Zuck, Thomas R. Pooley, H. W. Kice. The Committee of Arrangements was left in abeyance for appointment by the newly elected President.

The main feature of the meeting was a paper by John Victor Donnet, Pathologist, of West Side Hospital, New York City, whose subject was "Pathogeny of the Sequelae of Cholecystectomy".

Dr. Donnet's paper was of extreme interest, dealing with the history of his subject, stressing the excretion of bile following cholecystectomy, the effect of cholecystectomy on the gastro-intestinal tract and giving the following résumé:

"The study of the sequellae of cholecystectomy when based upon purely experimental findings shows that the amputation of the gall-bladder determines definite physio-pathologic disturbances.

(1) After a period of about 30 days, the extra-biliary tract is dilated. This dilatation is progressive and reaches ultimately the intra-hepatic ducts.

(2) At times the ectasia of the cystic stump is such that it resembles a gall-bladder of neo-formation.

(3) Histological studies show that we are not dealing with a regenerated gall-bladder.

(4) To the dilatation of biliary tract corresponds

a progressive destruction of the epithelium with fibrous transformation of the walls and degeneration of the elastic tissue.

(5) The biliary tract becomes infected; and the virulence of the intestinal flora is excited.

(6) The rhythm of the excretion of bile is markedly disturbed.

(7) The digestive functions are modified mainly as far as the assimilation of fats is concerned.

(8) When the physiological function of the gall-bladder has stopped, pathological changes similar to post-cholecystectomic sequellae appear.

(9) The idea that a cholecystectomy does not create important perturbations is not well founded.

(10) Practical conclusion: A cholecystectomy is justified only when the function of the gall-bladder is profoundly alterated."

(The paper has been submitted for publication in the Journal.)

Pathologist T. B. Christian of the State Hospital at Greystone Park led the discussion of Dr. Donnet's paper and was in full accord with the views of the speaker on this subject, emphasizing the danger of removing the gall-bladder at random and the necessity for judgment in avoiding possible damage by its useless and unnecessary removal. Dr. Reed also participated in the discussion. The paper and its discussions held the rapt attention of the audience and, at the conclusion, Dr. Donnet was accorded cordial manifestations of appreciation and a rising vote of thanks.

An interesting case was reported by Dr. Theodore Lindberg of the medical staff of the State Hospital; this included a chronological history from February 1918 to the admission of the patient to the institution in May 1933 and during the hospital residence of the patient. As far back as 1918 there was inability to see, spots before the eyes and pain in the eyes; these symptoms at that time lead to a diagnosis of exophthalmos of the right eye and paralysis of the third, fourth and sixth cranial nerves, with no symptoms of intracranial pressure. In 1920, a diagnosis of brain tumor was made; there was marked paralysis of the external rectus muscle. At that time a right sub-temporal decompression was done. In 1929, a right facial paralysis developed with corneal anesthesia of the right eye which appeared somewhat exophthamic. In 1930, there was extensive ulceration of the cornea which necessitated removal of the eye. In 1931, there was deafness of the right ear. In May 1933, when the patient was admitted to the hospital, the psychosis was characterized by confusion, irritability, inability to think, loss of interest, suicidal threats, fears that she might harm someone or herself and indications of auditory hallucinations. Dr. Lindberg also reported complete mental, physical, neurological and laboratory findings. The postmortem revealed after stripping back the scalp an elliptical decompression opening in the skull measuring about 2½ x 3 cm. The edges of this were thinned out and there was a herniation of the cortex of about 2 mm. Lifting off the brain revealed a roughly spherical firm tumor mass about 6 cm. in diameter, or somewhat smaller than a tennis ball. This was adherent to the right orbital fissure and the underlying bone of the middle fossa. It stripped off fairly easily, revealing bone necrosis, evidently due to pressure, and the orbital fissure was enlarged to a roughly circular opening about 2½ cm. in diameter. The tumor mass was not adherent to the brain structure. Practically the whole of the right temporal lobe was atrophied due to pressure. This tumor evidently arose from the optic sheath, the remnants of which are attached to the mass anteriorly. The remains of the fatty and connective tissue that lie behind the eye-ball are connected with the distal end of the optic sheath. A report from the Pathological Department classified this mass as a Glioma.

In connection with the case, Dr. Lindberg showed excellent photographs and the specimens were viewed and examined with much interest.

Dr. F. H. Morrison, of Newton, reported an interesting case of congenital hypertrophic pyloric stenosis. The case aroused much interest; the discussion was participated in by Dr. Donnet, also Dr. Curry and Dr. McMurray who discussed a similar case that was operated on 4 weeks after birth; the subject now is 18 years old and has been free of symptoms since the operation shortly after birth.

An appetizing luncheon was enjoyed in the Nurses' Dining Hall, for which the President, in behalf of the members and guests, expressed full appreciation to Superintendent Curry, as well as for his coöperation in making the State Hospital and its facilities available for the meeting. Responding, Dr. Curry expressed his pleasure at having the meeting at the hospital and stated that this was in harmony with his policy to have the medical men of Northern New Jersey, from which counties the hospital receives patients, come to the hospital as often as possible and become better acquainted with the work that he and the Medical Staff are endeavoring to perform.

ATLANTIC COUNTY

Staff Meeting of the Atlantic City Hospital

The Complications of Radium Therapy in in Gynecology

Wm. Edgar Darnall, A.M., M.D., F.A.C.S.,
Atlantic City, N. J.

The alluring advertisements of commercial agencies who rent radium, urging the general practitioner to send a description of the case and they will forward directions for its use, would lead one to believe that any one can apply it without special training in the technic or skill in its application. On superficial thought acquiring this knowledge seems comparatively easy as the application seems simple. It must not be forgotten, however, that often the things in medicine and surgery that seem simple and easy are the things that require the most judgment and the greatest amount of skill. Radium is a two-edged sword and its use is far from simple. Correspondence schools in radium therapy are dangerous to the inexperienced.

In order to appreciate this it is necessary to have some knowledge of the action of radium and what we are trying to accomplish by its application. The proper dosage of radium should destroy cancer cells, for which the gamma rays seem to have a selective action, but should not destroy normal cells. The beta or burning rays should be properly screened so as to make them inactive, while the gamma rays applied to the tissues destroy the cells of cancer. Various metal containers of platinum, gold, silver or brass are used for this purpose. Otherwise extensive destruction of normal tissues would take place from the burning action of the beta rays.

Too large a dose of radium will result in the destruction of normal tissues and will produce extensive necrosis, with resulting septic absorption, hemorrhages, injuries of adjacent structures, fistulas into other viscera and other tragic results.

Too small a dose may fail to destroy the cancer cells and may even stimulate them to greater activity.

Too frequent applications with too large doses may result in what is known as "late reaction" causing a slowly developed obliterative arteritis and devitalizing the tissues. This process may cause a chronic cystitis or proctitis, ulceration of the bladder or rectum, which is very stubborn to treatment, or fistulas which may occur from the breaking down of devitalized tissue as much as 6 months to 2 years after the radiation.

Not only must one be educated in the appreciation of the multiform complexities of cancer, but it is equally as necessary to have personal experience or training over considerable periods of time before one can feel competent to treat this disease with radium. The location and extent of the disease, the type of cell, the general physical condition of the patient and the frequent follow up of cases, all call for careful study and are essential to success in radiotherapy. Otherwise symptoms varying from temporary and mild discomfort to most distressing complications involving prolonged suffering and even death may occur.

Bladder and rectal symptoms may be avoided or greatly minimized by packing the rectum back posteriorly and the bladder anteriorly with gauze in the vagina to the limit that the vagina will hold. A retention catheter in the bladder will keep it collapsed and as far distant as possible.

Pathogenic bacteria of many kinds are apt to be associated with a sloughing ulcerated carcinoma of the cervix, causing foul discharges. It is important that antiseptic douches be given in such a case several days before radium is applied, else the patient may develop a severe septic infection resulting in her death.

Every case should be carefully examined to exclude disease of the appendages for here old infections may be lighted up and a fatal general peritonitis ensue.

A general physical survey with especial attention to the study of the blood is of the greatest importance. A large percentage of cases of carcinoma are suffering from severe secondary anemia when they are first seen. All cases whose blood count is in the range of two and a half to three million red cells, with a hemoglobin of only 40 or 50 per cent should be transfused before treatment with radium. Patients with severe anemia sometimes die very suddenly with symptoms simulating pulmonary embolism. It is hazardous to give it under these circumstances, until the blood has been brought up to the proper level.

The soundest judgment should be exercised in giving radium to younger women with idiopathic bleeding conditions in which no pathology can be elicited. Careful endocrine study and other methods of treatment should always be tried first. Small dosage of from two to four hundred miligram hours should be used even if it becomes necessary to repeat the dose. Overirradiation unwisely done may permanently destroy the menstrual function often with tragic results, if marriage is contemplated.

In order to know the results of our work careful follow up examinations should be made about every 6 weeks. It may be necessary to make further applications of radium to a cervix that is not entirely free from carcinoma. In this event each successive dose should be considerably smaller than the original dose, or the dose preceding it.

Finally, it is just as important that men should be properly trained and experienced in the use of radium as they should be to do surgery, so that they may avoid, on the one hand the dangers and complications which may occur in over radiation; or on the other hand the failure to destroy the disease by insufficient radiation.

BERGEN COUNTY

Charles Littwin, M.D., Reporter

The regular meeting of the Bergen County Medical Society was held on October 10, 1933 at the Hackensack Hospital, Dr. Alexander presiding. Due to the absence of Dr. Snedecor and Mr. Whitehead, Dr. Knowles was appointed Secretary for the evening. The minutes of the Executive Committee were approved as read.

Election of new members as follows: To Regular Membership, F. Chester Forte, Hackensack. From Junior to Regular Membership: B. Arthur Smith, Ridgewood; Samuel Legato, Cliffside Park; Yates S. Palmer, Edgewater; B. G. Morrison, Wood-Ridge; William C. Rucker, Hackensack; P. A. Patti, Leonia. To Junior Membership: B. J. Ellmers, Bergen Pines; Vincent Costabile, Lyndhurst.

Mr. Chandler, Chairman of the Bergen County Health and Sanitary Association, suggested for adoption a standard set of regulations for quarantine of contagious diseases. He stressed the point that at present there are no standard regulations and the subject was in a chaotic state throughout the County. Mr. Chandler suggested a tentative code of regulations. This code was adopted.

Dr. Corn was then called upon to report on the Post-Graduate Courses for the coming year. One course, offered by Rutgers University on a subject to be chosen, would not cost more than $10 per man. There was quite an active response and it was moved and carried to accept a course, the subject of which was to be chosen later. He also suggested that the Chiefs of the various departments of the hospitals in the county offer gratis short courses in their various specialties. This subject would be worked out and a more comprehensive plan would be reported upon at a later date.

The meeting was then turned over to the Scientific Committee and Dr. Wilson introduced Dr. Howard Fox, of New York City, who gave a lantern slide demonstration of the "Diagnosis and Treatment of Some Common Skin Diseases". This was a very practical demonstration and was enjoyed by the members.

The next subject for discussion was the "Medical Relief Plan in Bergen County". The subject was very ably presented by Mrs. Henrietta Hawes, Director of Relief, Bergen County, and by Colonel J. H. Bigley, State Manager Department of Standards and Research of the Emergency Relief Administration. There was a general discussion of the entire plan.

A collation was served about 11.30 just after adjournment.

BURLINGTON COUNTY

Report of E. R. A. Committee

INTERPRETATION OF REGULATIONS

Your committee found no difficulty in interpreting the provisions of the first 3 paragraphs in the section dealing with "Relations with Clients and Physicians". Your committee, however, wishes to emphasize the fact that in caring for patients for a period exceeding 2 weeks, it shall be necessary for a patient to obtain a written renewal of the

authorization for medical care from his local Emergency Relief Director, irrespective of whether the number of visits has been 10 or the total expenditure for this duration has not exceeded $20.

When a chronic case has an acute flare-up, the patient should apply to his local Emergency Relief Director for an authorization as provided for in an acute condition; and when the acute phase has subsided, the physician should notify the Emergency Relief Director, to reinstate the patient to the original status.

Your committee finds there is no Emergency Relief Administration in the following townships: North Hanover, Southampton, Chesterfield, Riverton, Cinnaminson, Springfield and Wrightstown. Service to indigent people residing in these districts is at the physician's own risk, but may be paid for provided such service is reported to the County Office of the Emergency Relief Director, Mr. Charles Krug, Armory Building, Mt. Holly, N. J., and, after investigation, is approved by that office.

Your committee desires to state that in order to obtain authorization for medical care, it is not necessary that the recipient receive assistance in other respects from the Emergency Relief Administration, and that such medical relief may constitute a special or a single phase of emergency relief activity.

The committee wishes to state that the status of charges made by those physicians who engage in x-ray, physio-therapy and laboratory procedures in their own offices, is now in the process of being adjucated by the State authorities and that further information on this subject will be available as soon as your committee is informed of their decision.

Your committee is informed that emergency operations performed in physicians' offices, consultations and anesthesisa, shall be reported within 48 hours, or when not emergency procedures, shall be undertaken only upon previous and special authorization from the local Emergency Relief Director.

Nursing services shall be authorized and paid for, on form 18, the authorization being procured in exactly the same manner as for physicians' services. If the nurse employed by the family is already receiving a salary from any charitable organization or municipality, she is not eligible for compensation under the terms of emergency relief.

Remuneration Program

The State Emergency Relief Administration has indicated that physicians' services shall be rendered on the basis of from ½ to ⅔ of the average prevailing rates. Realizing that in a majority of communities in this County, house calls are made at the rate of $1.50 and office patients seen for $1, your committee endeavored to prevent the application of the general rule of the State Code cited above, which might have brought your fees as low as 75 cents for house calls and 50 cents for office visits. After a prolonged discussion with the County Emergency Relief Directors, your committee was able to effect the following compromize, viz., $1.50 for house calls, such calls to be interpreted as those extending within a radius of 3 miles, and office fees at the rate of $1 per visit. In making house calls in which more than one patient is seen, separate authorizations must be procured from the local Emergency Relief Director for every patient, and the charges for seeing such additional patients in any one family shall be computed on the basis of an additional office fee of $1 per patient.

The question of remuneration for distances covered in making house calls beyond the 3-mile limit as well as rates for night calls, is in process of determination by the State authorities.

A physician who elects to attend an emergency relief patient who resides beyond the physician's 3-mile limit, but within the 3-mile limit of another emergency relief physician, will understand that he will receive for such calls only the regular fee of $1.50.

Your committee was able to obtain as an obstetric fee the sum of $25.00. Where there has been no pre-natal care, emergency provisions prevail; and where complications delay convalescence for a period longer than 2 weeks, authorization for such additional services shall be procured as for an acute illness. Details of pre-natal and post-natal care are required for the purpose of auditing the account and in conformity with the program for maternal welfare being carried out in the state.

The committee recommends that the County Emergency Relief Director impress upon his deputies and the local Relief Directors, that the patient has the right to select any physician on the roster, and that no deputy or local director shall through any act or suggestion, be permitted to influence the patient's selection.

The remaining provisions in the code of regulations, being self-explanatory, seem to need no further interpretation.

Your committee desires to inform the physicians of Burlington County that engaging in emergency relief work does not carry with it the necessity for determining the eligibility of their patients for relief; but when a physician deems that circumstances warrant financial assistance, the County Emergency Relief Director will appreciate reference of such cases to his notice; and it will be entirely ethical for a physician to advise families of the availability of relief.

Your committee recommends to the County Medical Society that the position of municipal or civic physicians be abolished, or that physicians holding such positions, resign during the period of the emergency. In districts where there is no Emergency Relief Administration, it is obvious that such physicians are grossly overworked and underpaid. On the other hand, in districts where Emergency Relief Administration is in effect, all physicians are equally privileged to participate in its remunerative returns, and it is manifestly unfair for any so-called "civic" physician to receive extra salary for doing no more than his colleagues are doing.

Ex-officio, President, John S. Conroy, M.D.
Nathan Thorne, M.D.
Richard D. Anderson, M.D.
E. J. Haines, M.D.
J. Howard Hornberger, M.D.,
Sec'y to the Committee
Jos. M. Kuder, Chairman.

August 31, 1933.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The annual business meeting of the Camden County Medical Society was held in the Camden City Dispensary Building, October 3, 1933, at 9 p. m., Albert B. Davis presiding.

The name of Lee J. Hammett, 760 North 27th Street, Camden, N. J., was presented to the membership for election. He was duly elected by ballot.

The applications for membership of the following were read for the first time: Doctors William T. Read, Jr., 429 Cooper Street; Banks S. Baker, 3021 Mt. Ephraim Avenue; David L. Andrus, 805 Cooper Street; Joseph M. Stein, 1004 Newton Avenue; Arthur G. Pratt, 516 Cooper Street; Grant O. Favorite, West Jersey Homeopathic Hospital, all of Camden, N. J., and Thomas H. McGlade, Camden Tuberculosis Sanatorium, Lakeland, N. J.

Dr. T. K. Lewis read the treasurer's report. This report was audited and found correct by Drs. E. B. Rogers and Pierce Shope.

Dr. E. C. Shull presented the Historians's report. This presentation was rewarded with grateful applause.

Dr. E. G. Hummel reported the meeting of the State Public Health Committee which was held this afternoon, October 3, in Newark, N. J. He touched upon the Detroit Plan, as outlined at this meeting. He also stated the desire of this Committee to foster a state-wide campaign of immunization against diphtheria during the coming year.

Dr. Lippincott, past State President, was invited to assume the President's chair during the presentation of the President's annual address. Dr. Albert B. Davis, retiring President, read his address which was graciously received by the Society and on motion of Dr. T. B. Lee, was ordered sent to the State Journal for publication.

Dr. L. L. Glover read the report of the Nominating Committee. On motion from the floor Drs. B. F. Buzby, Chairman, George B. German and C. R. Hutcheson were nominated as members of the Nominating Committee of this Society for 1934. Following this addition to the regular ballot, it was moved and seconded that the Secretary cast a ballot for the report of the Nominating Committee. The following officers and delegates were unanimously elected:

President, T. B. Lee; Vice-President, F. William Shafer; Secretary, Robert S. Gamon; Treasurer, Thomas K. Lewis; Reporter, Vincent Del Duca; Historian, E. C. Shull; Censor, Albert B. Davis; Trustee, T. B. Lee.

Delegates to N. J. Medical Society (to serve 3 years): J. Edgar Howard, Joseph E. Roberts, Thomas K. Lewis. Alternates: H. F. Palm, Joseph Lovett, W. J. Barrett.

Committee on Scientific Work: W. H. Jack, Chairman; O. R. Kline, J. S. Shipman.

Delegates to Atlantic County Medical Society: J. W. Crowley, W. D. Evans, I. E. Deibert; To Burlington County Medical Society: P. M. Mecray, A. H. Shafer, R. K. Bush; To Cape May County Medical Society: W. W. Kain, E. A. Farrell, H. I. Goldstein; To Cumberland County Medical Society: A. M. K. Maldeis, W. F. Moore, G. F. West; To Gloucester County Medical Society: H. F. Palm, E. M. Richardson, O. R. Kline; To Salem County Medical Society: L. L. Glover Lavinla Clement, M. R. Hummel.

Nominating Committee of State Society: T. B. Lee; of Camden County Medical Society: B. F. Buzby, Chairman, George B. German, C. R. Hutcheson.

Managers Camden City Dispensary: Thomas K. Lewis, P. M. Mecray, A. H. Lippincott, J. E. L. Van Sciver, D. F. Bentley, J. E. Roberts, J. L. Mahaffey, T. B. Lee, W. W. Kain.

The Secretary read a communication from the office of the Secretary of the State Medical Society, one which stated the Honorary members of the Component Societies in the State are not published in the Official List nor are they members of the A. M. A., unless the annual State Society dues are paid by the Component Society. Dr. B. Buzby moved that the treasurer of our Society pay to the State Society the annual dues of all Honorary Members of this Society for the ensuing year. This motion was discussed by Drs. I. F. Deibert, T. K. Lewis, E. G. Hummel, and B. F. Buzby. Upon presentation of the motion, it was passed.

Dr. E. B. Rogers moved that in consideration of the fact that the State Society dues are specified as $13.00 for the ensuing year this Society's dues be $18.00. This motion was passed unanimously.

The retiring president, Dr. Albert B. Davis, transferred the gavel and chair to the incoming president, Dr. Thomas B. Lee, who made a few brief remarks; following this the meeting was adjourned.

Forty-three doctors were present.

CUMBERLAND COUNTY

E. S. Corson, M.D., Reporter

The 115th annual session of the Cumberland County Medical Society was held at the Hotel Cumberland, Bridgeton, with its President, Dr. J. H. Winslow in the chair. The Society was invited to hold its January meeting at the Training School at Vineland. The following officers were elected unanimously: President, Ray Simkins; Vice-President, S. D. Bennet; Secretary, E. C. Lyon; Treasurer, H. H. Wilson; Reporter, E. S. Corson; Censor, C. M. Gray; Delegate to the State Convention, E. H. Van Deusen; Alternate, H. B. Walker; Nominating Committeeman, H. G. Miller; Alternate, Leslie E. Myatt.

Dr. Myatt, as chairman of a committee to cooperate with the E. R. A. program of care for the needy sick, reported that his committee was unable to obtain the authorization of the Regional Chairman to proceed along the lines laid down by the regulations. Doctors in adjoining counties seem able to treat the needy sick and obtain their fees in accordance with the regulations.

Dr. Anthony Pino was called on, as a newly-elected member of the Society, to make a few remarks. This, he did, most graciously. Dr. LeRoy Wilkes, the newly-appointed Executive Secretary of the State Society, gave a very lucid explanation of the manner in which the ERA operates under State Medical Society supervision in the northern part of New Jersey. He explained that medical care of the indigent had been provided for in the ERA code as part of its program, and that it was but right to give it a fair trial.

Dr. R. L. High, of Philadelphia, gave an illustrated lecture on "Solution Normet". This solution, named after the celebrated French physician Normet, is offered as a substitute for blood when transfusion is needed. The picture illustrated a dog bled to the point of dying: 60 seconds after this solution was injected into the animal's veins, he was on his feet, eating and drinking. No other substance is known to produce this response. Normal salt solution has been used for this purpose, but the relief it affords is only temporary; metals other than sodium seem to be necessary. Indeed there are some metals in the blood that can be detected only by the use of the spectroscope. It has been said that iron is the essential metal, but manganese activates all the metals in their chemical reactions. Dr. High explained that the variation in coloring in leaves and plants was due to differences in the alkalinity of the chlorophyl. He suggested that solution Normet be available for emergency transfusions and for cases in which blood produced no beneficial effect.

Dr. Allen G. Ireland of the State Department of Public Instruction explained the application of the E. R. A. regulations to physicians in their work of treating the indigent. Physicians are becoming more conscious of the change in the public health programs of the State and are realizing that many persons, able to pay, are receiving free care. He emphasized the benefits of pre-school treatment in the administration of diphtheria toxin-antitoxin to children less than 1 year old, and discussed the value of small-pox vaccination in the same age group.

The Gloucester County Medical Society, it was reported, has formulated a plan for better coöperation between the State agencies and the private doctor. Dr. Wilkes suggested that the local physician speak more frequently before welfare organizations, and asked if the Society would offer its services in this capacity.

ESSEX COUNTY

Earl Le Roy Wood, Reporter

Dr. Edward W. Sprague was elected President of the Essex County Medical Society at its 118th Annual Meeting, held Thursday evening, October 12, 1933, at the Academy of Medicine, Newark. More than 300 members attended.

Dr. Sprague, who was Vice-President last year, succeeds Dr. William H. Areson, of Montclair. Dr. John F. Condon, of Newark, was elected to succeed Dr. Sprague as Vice-President. Reëlected were: Secretary, Dr. Frank W. Pinneo, of Newark; Treasurer, Dr. Robert H. Rogers, of Newark; and Reporter, Dr. Earl Le Roy Wood, of Newark.

Drs. James T. Hanan, of Montclair; David A. Kraker, Alfred Stahl and A. Charles Zehnder, of Newark, were elected to the Council of the Society for 2-year terms. Dr. Stahl was named Essex County member of the Nominating Committee of the New Jersey State Medical Society, and Dr. Zehnder was chosen Alternate in that position.

Fifteen Delegates and 12 alternates to the State Society were elected for 3-year terms. They are: Delegates: Richard D. Freeman, South Orange; Brison B. Ransom, Jr., Maplewood; George Blackburne, William D. Crecca, J. Wallace Hurff, Edgar A. Ill, Francis J. McCauley, Henry B. Orton, Erwin Reissman, Edward Steiner, William A. Tansey, Harold A. Tarbell, H. Roy Van Ness, Frank W. Pinneo and A. Charles Zehnder, all of Newark. Alternates: Thomas W. Harvey, Jr., Orange; John W. Coburn, East Orange; Den Marquis, East Orange; E. L. Minard, East Orange; N. A. Antonius, Henry C. Barkhorn, Julius Levy, L. Mancusi-Ungaro, Eugene Parsonnet, Joseph W. Siegel, Ernest Tutschulte and David A. Kraker, of Newark.

The President, Dr. William H. Areson, addressed the Society. (Published in this issue.)

The committee on coöperation with the State Emergency Administration reported an arrangement is being made, through the State Society, whereby organized physicians will care for the indigent at low rates and be reimbursed by the State on a pre-arranged schedule. The vast majority of the Essex County Medical Society members are answering "Yes" to the recent questionnaire showing a cheerful desire to coöperate and make effective the County Medical Relief Plan as explained in the New Jersey State Medical Journal, August 1933, pages 591 and 593. The Relief Advisory Committee for Essex County is Drs. E. Zeh Hawkes, Max Danzis, Henry C. Barkhorn, of Newark; William H. Warner, of East Orange, and Irving L. Farr, of Montclair.

Recently some inter-county correspondence originated in Morris concerning the policies of the President of the State Society, the Welfare Committee, etc. Apropos, the following was passed: "Resolved: That the action of the Council in endorsing the plans and purposes of Dr. Frederic J. Quigley, the President of the State Society, is approved and that we, the members of the Essex County Society in Annual Meeting assembled, wholcheartedly express our confidence in his loyalty and judgment and do pledge him our support" The Essex County Council had at a regular meeting September 25 voted their amazement at the correspondence, saying, "The members of the Essex County Society have had such knowledge of the principles and the work of Dr. Quigley in all his offices and work for the State Society for years, that they have confidence in his loyalty and judgment, and do wholeheartedly endorse his policies (while still retaining liberty of opinion on any particular matters)."

After reading the protest of the Council against interpolations in the State Society transactions, which was as follows: "The Council of the Essex County Medical Society resents the introduction, by the Secretary of the State Society in the Official Transactions, of interpolated remarks or statements not made on the floor of the House of Delegates at the State Society meeting held in Atlantic City on June 6, 1933, and demands a proper investigation and suitable action by the Board of Trustees of the Medical Society of New Jersey", the County Society passed the following: "Resolved: That the action of the Council on publication of the State Society transactions free from interpolations is approved."

A resolution was passed concerning the relation of the Organized Medical Profession to the Hospital Council of Essex County. This latter body with its organization purposes, desires and activities was described in the February 1933 Journal. "Resolved: That the action of the Council in declining to accede to the request of the Hospital Council of Essex County that our President be a member of their Executive Committee is approved."

It was brought to the attention of the Society that the Board of Education of Newark was planning to require physical examinations of applicants for appointments as teachers in the public school system. Therefore, it was resolved that this examination and certification be made only by physicians regularly licensed to practice medicine in New Jersey and members of the New Jersey State Medical Society, the physicians to be selected by the applicants.

A committee composed of the following, John Francis Condon, H. Roy Van Ness, James H. Lowrey and Frank W. Pinneo, during the past year devoted considerable time to investigating various agencies for financing and collecting doctors' accounts. They reported: "In submitting its report, the committee wishes to state that several plans for the Financing and Collecting of Doctors' Accounts have been submitted by a number of companies. After many meetings, at which we have carefully scrutinized and discussed each plan, we have decided that it would be premature at this time to recommend the approval of any particular plan. Each submitted plan has attractive merits and the persistent solicitations of the various companies emphasize the fact that there is a demand for some plan for the Financing and Collecting of Doctors' Accounts. Many members of the profession are subscribers to these companies and some have endorsed them over their signatures. This Committee believes, from its experience in

handling this subject, that the incoming administration would do well to continue where the committee has left off as it is beyond dispute that the rank and file of the profession are deeply interested This recommendation is made without thought of dictating a policy and is merely offered as a suggestion."

Dr. Rogers in his report as Treasurer said the Society found itself in unusually good financial condition considering the times. He said that the County dues for 1934 would be $2 and the State $13, making a total of $15 for each regular member. The Associates will pay $5.

Dr. Sprague, as Chairman of the Public Health Committee, said plans were under way in coöperation with the State Society for planning for a public relations program on the part of organized medicine throughout the State. Other committee reports were made by Dr. Elmer G. Wherry for the Essex County Medical Milk Commission, Dr. W. B. Mount for the Maternal Welfare Committee, Dr. J. L. Fort for the Committee on Illegal Practitioners, and Dr. Henry B. Orton for the Committee on Cancer Control.

Dr. Charles A. Wallack was elected a regular member and the following were elected Associate members: Raymond N. Allen, Gerald Weldon Hayes, Olafur W. Johnson, Franz Jost, Frederick Charles Licks, Philip Mangogna, John F. Masterson, Fulton Massengill, Carl A. Nacca, Clifford W. Quad, Nelson White Sisson and Frank Varmus.

A new printing of the revised Constitution and By-Laws in artistic booklet form and in convenient pocket size was distributed to the members. Commendation should be extended to the committee responsible.

Memorial tributes were made to the following members who departed during 1932: Samuel Simon Bruington, Wellington Campbell, Henry Jesse Gilbert, Ignatz Kaufman, Charles Frederick Lehlbach, Frank Leslie Martine, Emanuel David Newman, Lewis Isadore Nisnoff, Walter Post, Emanuel Schwartz, David Clark Thompson, George Nelson Waite and Henry Bayard Whitehorne. The obituaries were printed in booklets and distributed at the meeting. Dr. Floy McEwan and Dr. Harold Tarbell constituted the Necrology Committee.

The Academy of Medicine of Northern New Jersey

Transactions of the Section of Medicine and Pediatrics

Benjamin Saslow, M.D., Secretary

The 166th monthly meeting of the Section on Medicine and Pediatrics of the Academy of Medicine was held on October 10. The meeting was called to order by Chairman Polevski at 9 p. m. Secretary Saslow read the minutes of the last meeting, held on May 9.

The speaker of the evening was Dr. Russell L. Cecil, Professor of Clinical Medicine at the Cornell University Medical School. His subject was "Acute Rheumatic Fever".

Dr. Cecil began his talk with a description of the specific lesion of acute rheumatic fever, the Aschoff body; he reviewed its histological appearance, its sites of predilection, its life history and course from its inception until its final metamorphosis into a tiny fibrous scar. Bacteria, Dr. Cecil pointed out, have never been isolated in the Aschoff body, although injections of hemolytic streptococci into rabbits will bring about the formation of these specific lesions on their heart valves. A most lucid description of the inception and pathologic course of the verrucous deposits upon the heart valves was then given.

The speaker felt that acute rheumatic fever definitely depends upon sudden changes in climate, because such climatic fluctuations increase the incidence of infections of the upper respiratory tract, and particularly the tonsils. He stressed the rarity of acute rheumatic fever without a preceding upper respiratory infection. Coburn has shown that there is a striking increase in the number of hemolytic streptococci in the throats of some children in inclement weather (autumn and spring), and that these children will frequently develop an acute attack of rheumatic fever in the advent of their suffering from an upper respiratory infection.

Dr. Cecil pointed out that the study of acute rheumatic fever is particularly important in children because of the frequent incidence of cardiac complications. About 70% of children having acute rheumatic fever have a cardiac complication, and the incidence of this complication increases with each subsequent attack. In adults, however, joint symptoms are predominant, the heart symptoms being relatively insignificant.

The onset of cardiac complications is manifested clinically by tachycardia, coupled rhythm, accentuation of the third heart sound, various stages of heart block and auricular fibrillation. There is such a protean and general involvement of the peri-, myo-, and endocardium, that the general term, rheumatic carditis, is at present used to delineate the cardiac damage.

Another common, but often unmentioned, complication, Dr. Cecil emphasized, is rheumatic pleuritis. This often occurs without heart symptoms, and is frequently mistaken for tuberculosis.

Subcutaneous nodules may occur, and Dawson has demonstrated that these nodules are similar to the lesions found in and around the joints in rheumatoid arthritis. In fact, about 6% of the cases of acute rheumatic fever in adults continue on into a true rheumatoid arthritis. Erythemata occur not infrequently in the course of this disease.

The blood picture is characterized by a leukocytosis of 12,000 to 25,000, with an increase in the immature band forms. The sedimentation rate of the blood is now used as a means of determining the persistence of an attack of acute rheumatic fever. A rapid sedimentation rate shows that the infection is still active.

Chorea is a common complication, and its onset heralds the presence of cardiac complications in about 50% of the cases. The kidney is relatively immune from complications.

Dr. Cecil pointed out that it is occasionally most difficult to diagnose a case of acute rheumatic fever, as it may closely simulate an acute infectious arthritis. An important differential point is the frequent involvement of the smaller joints and spine in infectious arthritis.

The prognosis in this illness is good except when the heart is involved. It is most unusual to see a death from acute rheumatic fever *per se*. Dr. Cecil strongly feels that the cause of the illness is a short chain, green indifferent pleomorphic bacillus. The hemolytic streptococcus found in the tonsillar tissue apparently is able to change into this green non-hemolytic form when it reaches the blood and joint fluid; he believes that the intense controversy and difference in opinion among independent observers, as to the infecting bacterial agent, are due to its pleomorphic character in various types, and H ion concentrations of different culture media. E. C. Rosenau, Birkhaug, Cecil and Small have all recovered this indifferent strepto-

coccus from the joints of patients suffering from this disease. Some believe that this organism is a secondary invader, and that the infection is caused by a filterable virus. A point in favor of Cecil's opinion is the fact that intradermal injections of this hemolytic streptococcus, will give a specific wheal when injected into patients with acute rheumatic fever; a general anaphylaxis to the non-specific protein in the filtrate, however, could easily explain such a reaction.

Dr. Cecil's discussion of treatment was immeasurably practicable. He gives 30-40 grains of sodium salicylate or acetyl salicylic acid, 3 or 4 times a day, and feels that aspirin causes much less gastric irritation than sodium salicylate. He stressed that although these therapeutic agents ameliorate the joint symptoms, they certainly do not decrease the severity or incidence of heart complications. Swift, of the Rockefeller Institute, uses the salicylates in a much more heroic fashion. On the first day of treatment, he gives the salicylates in 15-grain doses every hour for 10 hours (150 grains). He cuts this dose in half on the second day, and then reduces it until he reaches a dose just below the point of toxicity; he maintains this dose until the symptoms are ameliorated. Neocinchophen is effectual if given carefully in 7½-grain doses, 4 times a day. This drug usually does not upset the gastrointestinal system. Amidopyrine in 5-grain doses, 6 times a day, is also very efficacious.

Digitalis should be used when tachycardia or auricular fibrillation supervenes. In an uncomplicated case, the patient should remain in bed for at least 2 weeks after the joint symptoms have subsided, in order to discourage the development of another attack, because with subsequent attacks, the probability of heart damage increases. The blood sedimentation rate is a good index of the presence and persistence of a cryptic infection.

Specific anti-streptococcic serum has been found unsatisfactory in this disease. However, Swift agrees with Cecil, that when used prophylactically, streptococcus vaccine decreases the incidence of the disease. The first dose of the vaccine should be 25,000,000; this should be increased slowly.

Environment and differences in hygienic conditions, Cecil feels, have a distinct influence on the prevalence of this disease. It is 20 times more common in the East Side than in the Park Avenue district of New York City. In England, it is strongly believed that tonsillectomy should be undertaken in every case. However, a Rochester group of observers which attempted this form of prophylaxis against a second attack of this illness, is not as optimistic as those abroad. Cecil urges that tonsillectomy should be performed on all patients with this disease after the attack has subsided, and if feasible, the child should be sent to a more equitable climate such as that of Arizona or Florida.

The discussion was opened by Dr. John Gray, who demonstrated the Aschoff body in several excellent lantern slides. Dr. Charles Teeter felt pessimistic about the newer therapeutic measures instituted in this disease, and felt that rest and salicylates were the only agents that were effectual. He suggested more attention to prophylaxis, and described a case of acute rheumatic fever that terminated in one of subacute bacterial endocarditis. Dr. H. Silver discussed the relationship between tonsillar infection and acute rheumatic fever. Dr. Max Maas was optimistic about intravenous therapy in this disease.

In closing the discussion, Dr. Cecil brought out several pertinent facts. He felt that intravenous salicylate therapy should never be employed, as the rectum could always be used as a means of introducing the salicylates into the body if the stomach were too irritable. He suggested that all foci of infection be eradicated after, rather than during an attack. The shift to the left in the Von Schilling count runs roughly parallel to the sedimentation rate of the blood. He stressed the impossibility of foretelling which patients, harboring hemolytic streptococci in their throats, would develop true cases of acute rheumatic fever. He emphasized the care required to avoid giving an excessive dose of streptococcus vaccine, because of the danger of an accentuation of symptoms by an allergic non-specific protein reaction.

The meeting was closed at 10.45 p. m. by the Chairman, Dr. Polevski.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The annual social session of the Gloucester County Medical Society was held October 19, 1933, at the Hotel Pitman, where an excellent dinner and fine program were enjoyed by the members and their wives.

Rev. E. Forrest Hann, of Woodbury, Camden District Superintendent of the Methodist Episcopal Church; Dr. Harold Jones, of the Jefferson Medical College, and Dr. Quigley, of Union City, President of the New Jersey State Medical Society, addressed the society.

Vocal solos by Dr. Henry L. Sinexon, of Paulsboro, and Miss Ethel Crain, of Woodbury, were greatly enjoyed, as were several piano selections by George M. Ashton, of Swedesboro. A harpist played during the dinner and on the program that followed.

Dr .C. .I. Ulmer, of Gibbstown, presented his annual award to the outstanding member, Dr. Sinexon, who received a gold medal.

Dr. William Pedrick, of Glassboro, President of the County Society, presided as toastmaster.

Those present were: Dr. and Mrs. William W. Pedrick, Dr. and Mrs. Charles Pedrick, Glassboro; Dr. and Mrs. Ralph K. Hollinshed, Dr. Edward Ristine, Westville; Dr. and Mrs. Ralph Wandall, Clayton; Dr. and Mrs. Henry B. Diverty, Dr. and Mrs. Fuller G. Sherman, Dr. and Mrs. William Brewer, Dr. and Mrs. Paul Pegau, Dr. and Mrs. J. Harris Underwood and Dr. and Mrs. E. E. Downs, Woodbury; Dr. and Mrs. C. I. Ulmer, Gibbstown; Dr. Oran A. Wood, Dr. Henry L. Sinexon, Paulsboro; Dr. and Mrs. S. C. Rhoads, Westville; Dr. and Mrs. Don Weems, Wenonah; Dr. and Mrs. T. M. Gairdner, Gibbstown; Dr. and Mrs. B. A. Livengood, Swedesboro; Dr. and Mrs. C. C. Sheets, Paulsboro; Dr. and Mrs. Samuel Ashcraft, Mullica Hill; Dr. Quigley, Union City; Dr. Emma Richardson, Camden; Dr. Howard F. Palm, Camden; Dr. Harold Jones, Philadelphia; Rev. and Mrs. E. Forest Hann, Woodbury; Dr. and Mrs. Oram R. Kline, Woodbury; Dr. and Mrs. H. W. Wright, Williamstown; and Dr. and Mrs. William E. Crain, Woodbury.

HUDSON COUNTY

Charles Sirken, M.D., Reporter

Report of Annual Meeting for Election of Officers

The regular meeting of the Hudson County Medical Society was held on Tuesday, October 3, 1933, at the Carteret Club in Jersey City. The meeting was devoted entirely to the election of officers and proved to be the most spectacular and exciting election ever held in the history of the Society. This stirring session was provoked by the clashes

between opposing factions within the Society for some time past. At the May meeting of the Society, Dr. Vincent Butler presented practically a complete list of nominations of candidates for offices in opposition to the nominations already presented to the Society at a previous meeting by the regular Nominating Committee. From this time on, both groups were diligently at work lining up the members of the Society for their respective candidates.

In the October issue of the County Society Bulletin, a page was reserved for each group to present to the membership the reasons for urging the election of their respective candidates. Dr. Berthold T. D. Schwarz, on behalf of the campaign council formed to elect the regular nominees of the Nominating Committee, made use of half of the page; but Dr. J. F. Norton did not avail himself of the space reserved for presenting the principles on which the candidates who were nominated, in opposition from the floor, stood. A record registration of 451 was attained apparently as the result of the acute interest in the election. The total number voting reached the unpreecedented figure of 380, only 71 members not participating in this election. All efforts were made to make the ballot secret. Voting started at about 9 p. m. and continued almost until midnight. When only a small number of ballots had been counted by 5 a. m., it was decided to recess until 3 p. m. the next day. On the latter day, counting continued until 4 a. m. and the last ballot was not counted until the early hours of Friday morning, the third day after the election. Printed sample ballots were handed out the night of election by the leaders of the group whose candidates were nominated from the floor. On these ballots were marked the candidates for whom this group wished the members to vote.

The closeness of the vote was a big surprise. Dr. B. T. Schwarz lost by only 6 votes the office of Secretary to Dr. Harry Perlberg. The following members were elected to the major offices: President, Daniel Street; Vice-President, E. J. Chapman; Secretary, Harry Perlberg; Treasurer, Charles B. Kelley; Reporter, John N. Connell; Trustee, Henry Spence; Censor, R. L. Ballinger; Member of Auditing Committee, J. Philip Stout; Members of Publication Committee, Harold Franklin, Nicholas M. Alter, Martin Marshak, and John D. Pellarin; State Nominating Committeeman, Joseph F. Londrigan; Alternate, Hugo Alexander.

The following report was received by the Secretary:

Report of "Committee to Consult with Dr. O'Hanlon on the Problems of the Medical Center"

"This committee was appointed by President Louis A. Pyle on February 24, 1933, with the following members: Hugo Alexander, William N. Barbarito, Charles B. Kelley, W. Wallace Maver and Donald Miner, Chairman. Dr. Pyle was present at all meetings.

The committee has had good attendance at its numerous meetings, both by itself and those with Dr. O'Hanlon, Medical Director of the Medical Center. I wish at this time to thank the members of the committee for their wholehearted coöperation on this problem.

After careful consideration and deliberation, this committee has come to the definite conclusion that the first and only step to be taken at this time is a thorough and complete reörganization of the present inadequate Staff of the Medical Center.

As evidence of the present Staff inadequacies, the following are a few examples: (1) There are today only 2 Attending Surgeons for all surgical patients, and one of these is on leave of absence. (2) There is no Attending Surgeon for nose and throat patients. (3) There is only 1 Attending Eye Surgeon. (4) There are no Associate Physicians and altogether too few Assistant Physicians to care properly for a hospital of 726 sick people, (5) A very large part of the care of the sick—including operations—is done by interns and residents, without the supervision of Staff members.

In furtherance of our conclusion, we have submitted to Dr. O'Hanlon definite suggestions and recommendations for a proper and adequate Staff reörganization. After a series of conferences with him we have received word from him during the past week giving us definite assurance that the majority of our recommendations were acceptable and that he felt that they could be put into operation in the future. We must admit, however, that up to the present moment, as far as we know, no attempt has been made to change the present set-up at the Medical Center.

This committee recommends that a continued effort be made during the ensuing year toward the solution of the Medical Center problem.

Detailed accounts of our conferences and Dr. O'Hanlon's communications are in the hands of the committee's Chairman for future reference by the Society." (Signed) Donald Miner, Chairman.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Secretary

The Mercer County Medical Society met on October 11 in the Trenton Country Club, President Proctor presiding. The minutes of the May and August meetings were read and approved.

This meeting was devoted to the Report of the Special Advisory Committee, authorized by the State Society, appointed by the President, to act in conjunction with the State Emergency Relief Administration. Dr. Wilbur Watts, Chairman, gave a most interesting and enlightening résumé of the several conferences held, relative to the activities of the County and City administrations, providing several topics for discussion.

These topics embraced Publicity, Selection of Physicians, Charges for Services Rendered to more than one patient in a household, and for medicines and supplies, City Physician work and other duties involved in caring for the indigent sick.

Dr. E. G. Meriwether of the New Jersey State Hospital was elected an Active Member of the Society. The applications of Drs. J. J. Belfer, H. L. Drezner, Max Friedman, A. J. Fessler, F. D. Hunter, F. M. Hammell, H. S. Urbaniak, M. R. Zentner and W. R. Peterson were read and referred to the Membership Committee.

A motion was made that the President appoint a committee to obtain information relative to Credit Associations, with the purpose of considering the organization or support of some such undertaking.

The president appointed the usual committee to arrange the Annual Banquet to be held in November.

MONMOUTH COUNTY

Robert A. MacKenzie, Reporter

Testimonial Dinner to Dr. James F. Ackerman

Leaders in his chosen profession of medicine, outstanding figures in the State's political life, fellow-practitioners and "old friends" from the North Jersey coast turned out 300 strong on September 14, 1933, to pay tribute to Dr. James F.

Ackerman, President of the Board of Governors of Fitkin Hospital.

At a testimonial dinner at the Berkeley-Carteret Hotel, Asbury Park, "Doctor Jim" was hailed as "a man who has sustained the best traditions of the old family physician".

Greetings from his State and city were brought by A. Harry Moore, Governor of New Jersey, and Clarence E. F. Hetrick, Mayor of Asbury Park. United States Senator Hamilton F. Kean and Circuit Court Judge Rulif V. Lawrence were present but did not speak.

The medical profession was represented by Dr. Claude A. Burrett, Dean of the New York Homeopathic Medical College, New York; Dr. Samuel A. Brown, Dean of University and Bellevue Hospital Medical College, New York; Dr. Frederic J. Quigley, Union City, President of the Medical Society of New Jersey; and Dr. Robert E. Watkins, Belmar, President of the Monmouth County Medical Society, sponsor of the testimonial. Dr. William G. Herrman, Asbury Park, was toastmaster.

In addition to the verbal testimony to Dr. Ackerman's popularity, a large number of telegrams were received. Among them was one from the Spring Lake Alliance of the Fitkin Hospital, in which a draft of $2,500 was enclosed. The money is to be applied to the fund for the Fitkin Hospital.

"We honor him chiefly as a general practitioner—an almost fabulous figure now," declared the Reverend Robert A. Whyte, of Philadelphia. "Dr. Ackerman could have been a success in business, in the pulpit or in the affairs of state," he pointed out, saying, "the source and secret of all his talents lie in his grace of perfect understanding of those with whom he deals."

Governor Moore made an inspiring address, in which he said, "Dr. Ackerman is an institution in this State and I am honoring myself in bringing him the tribute of the people of New Jersey. In the Fitkin Hospital is the soul of Dr. Ackerman; but his greatest monument, he has created in the hearts of the people."

Mayor Hetrick told how the guest of honor had come here more than 40 years ago and how he became "a moving force in the affairs of our town, county and State."

"We were stirred by his kindliness and the comfort he brought to many homes," the Mayor declared. Turning to the guest of honor, he said, "The spirit of love comes to you, Doctor Jim, from the hearts of many."

Dean Burrett brought greetings from the New York Homeopathic Medical College, from which Dr. Ackerman was graduated. He cited that Dr. Ackerman had kept pace with the many advances in science that have occurred since his graduation.

"This occasion calls to my mind the sad passing of the family doctor of which our guest is a fine example," Dean Burrett pointed out. Both he and Dean Brown, of Bellevue, also paid their respects to Mrs. Ackerman.

Dean Brown declared Dr. Ackerman was deserving of the term "beloved". He said the success of the honored guest was due to 2 phases in his life—he was a scientist and he had the gift of an outstanding personality. "He is the product of a period that produced great doctors," Dean Brown explained.

Dr. Quigley brought to Dr. Ackerman the felicitations of organized medicine in New Jersey, while the county organization's greetings were given by Dr. Watkins.

Dr. Ackerman responded to the tributes which were lavished on him, saying, "For a man to do his day's work for a number of years 40 or 50—deserves no commendation. No heart, no mind, no words can express my gratitude. If I am much of anything I am such because of the care, attention and affection I've had from my wife."

OCEAN COUNTY

Eugene G. Herbener, M.D., Reporter

The Ocean County Medical Society held a meeting on Thursday, September 28, 1933, at Murray's Log Cabin in Lakewood. The meeting was called to order by the President, Abraham Goldstein, at 6.30 p. m., with the attendance as follows: Drs. V. Disbrow, T. Thompson, C. Ripley, R. Halbach, W. Hayden, E. Sickel, F. Brouwer, A. Woodhouse, A. Towbin, E. Herbener.

As guest, we had Dr. Charles Bailey, of Long Branch, New Jersey.

The minutes of the previous meeting were read and approved. Applications for membership were referred to the Membership Committee.

The following committee on Emergency Relief was appointed: Drs. Abraham Goldstein, Chairman; W. G. Hayden, E. M. Sickel, A. Woodhouse, E. G. Herbener.

The communication received from Mrs. Evelyn Brown was referred to the committee consisting of Drs. A. Towbin, R. Halbach and F. Brouwer.

There was a general discussion of matters relating to our local society. This discussion will be continued at our next meeting.

A motion to adjourn was approved.

SALEM COUNTY

William H. James, Reporter

The Annual Meeting of the Salem County Medical Society was held at the Memorial Hospital, Salem, New Jersey, on Wednesday evening, October 11, at 9 o'clock.

Dr. W. T. Hilliard, of Salem, presided. After the regular business of the Society had been completed, we had the pleasure of hearing Dr. Ralph Burnstein, Professor of Dermatology at Temple University in Philadelphia. The doctor took for his subject the more common skin diseases such as eczema, ivy poison, impetigo contagiosa, etc.

As there is a severe epidemic of impetigo in the schools of Salem County, the lecture was a timely one. In one school, there were more than 50 cases since the beginning of the term in September. The treatment that seemed most effective was a 10% to 20% ointment of ammoniated mercury.

Dr. I. W. Knight, of the State Board of Health, gave a very interesting talk on the prevention of diphtheria in young children, especially those from 6 to 12 months of age. Toxin-antitoxin and toxoid are the best remedies at present, but workers are hoping to prepare a serum which will immunize the patient by one injection.

As this was the Annual Meeting, elections were held. The following officers were elected: President, W. P. Hilliard; Vice-President, Frank L. Perry; Secretary and Treasurer, David W. Green; Reporter, William H. James; Censors, Frank L. Perry, John M. Summerhill and William H. James.

A motion to set dues at $18 a year was adopted.

Dr. E. G. Evans, of Pennsgrove, was elected to membership.

The following guests were present: Dr. Knight, of Pitman; Dr. Hummel, of Merchantville, and Dr. Burnstein, of Philadelphia.

At the close of the meeting, the Society enjoyed a luncheon in the main dining room of the hospital.

UNION COUNTY

Russell A. Shirrefs, M.D., Reporter

About 90 members attended the Annual Meeting of the Society held on the evening of October 11 at the Elizabeth General Hospital. Dr. Emil Stein, retiring President, gave an address on "Our Relations to the General Public", in which he stressed the desirability of doctors taking a more active interest in public life. He also spoke of the necessity for compulsory automobile liability insurance, the fight against child labor, and the need for a campaign to "clean up politics". He included in his talk the subject of mosquito extermination and strongly advocated a larger appropriation for the purpose. Later in the evening, the Society passed a resolution to be sent to the Board of Freeholders in favor of increased appropriations for mosquito extermination work and advising of the menace to public health caused by the insects during the past Summer. Newly elected members are Edward T. Lynch, Elizabeth; S. Lawrence Samuels, Plainfield; and Charles F. Gibson, Summit. Eleven proposals were received for action at the next meeting. Officers elected are: President, Watson B. Morris, Springfield; Vice-President, Edward S. Krans, Plainfield; Secretary, George W. H. Horre, Elizabeth; Treasurer, Alden R. Hoover, Elizabeth; Reporter, Russell A. Shirrefs, Elizabeth; Censor, 1938, Jacob Reiner, Elizabeth; Board of Trustees, 1936, Harry H. V. Hubbard, Plainfield. Committee on Scientific and Literary Work: Joseph J. Labow, Elizabeth; Stanton H. Davis, Plainfield; C. B. Kinney, Summit. State Nominating Committee: Stephen T. Quinn, Elizabeth. Committee on Public Health and Legislation: 1938, Harry H. Bowles, Summit; 1934, Emil Stein, Elizabeth (to fill the unexpired term of W. B. Morris, resigned).

Guest speakers were Dr. J. B. Morrison, Secretary of the State Society, and Dr. C. C. Beling, Councilor of this District. Each discussed the work of his department. After adjournment, refreshments were served and a social hour enjoyed.

Westfield Medical Society

Frederick A. Kinch, M.D., Reporter

The October and Annual Meeting of the Westfield Medical Society was held Tuesday evening, October 10, 1933, at the home of Dr. L. H. Leggett, Jr. The usual order of business was suspended, and the guest speaker, Dr. Marie Pichet Levison, of New York, was introduced. Her topic was "The Problem of Birth Control". Included in her talk was a demonstration of some methods of contraception. The presentation was an interesting one, closely followed by the members. A general discussion followed, and the Society voted to express to Dr. Levison its thanks for her courtesy and for her instructive address.

The following officers were elected for the ensuing year: Lorimer Armstrong, President; Fiske Wood, Vice-President; E. Milton Staub, Secretary-Treasurer; Charles T. Decker, Comptroller; Frederick A. Kinch, Reporter. The Treasurer's books were found correct, with a comfortable balance in the bank. After a social hour spent in discussing cases and in general conversation, the Society voted an expression of its thanks to Dr. and Mrs. Leggett for their hospitality and adjourned until its November meeting.

Obituaries

BLANCHARD, Dr. Oliver R., former President of the Board of Education of Jersey City and a well-known physician, died of a heart attack late Saturday, October 14, 1933, in his home at 37 Clinton Avenue. He was 75 years old.

Born in Rockland County, New York, Dr. Blanchard attended Spring Valley Academy and Oswego Normal School, graduating from the latter in 1883. For a short period he was a student at Lafayette College, from which he later received the honorary degree of Bachelor of Science. After leaving Lafayette, he taught in Hasbrouck Institute, at the same time taking a medical course at New York University, from which he was graduated in 1891.

Dr. Blanchard practiced in Jersey City for 20 years, during which time he was on the staffs of the City and St. Francis Hospitals. He was one of the founders of Fairmount Hospital there, and President of it at his death. He served on the Board of Education for a number of years, and was President for a term.

He is survived by a widow, a step-daughter, Mrs. H. M. Stearns, and 3 sisters and 3 brothers.

FARROW, Dr. Jacob Willard, prominent physician and Democratic leader of Dover, died suddenly Saturday, October 14, 1933, at his residence, 44 West Blackwell Street.

Born in Flanders, Morris County, he was graduated from Long Island Medical College in 1895. He opened an office in Dover in 1897.

Dr. Farrow served during the World War as Captain in the Medical Corps and was stationed at Fort Oglethorpe, Georgia, and at Camp Sevier, Greenville, South Carolina. He had represented the Democratic party at county, state and national conventions and was a delegate to the Baltimore convention which nominated Woodrow Wilson for the Presidency.

He was a member of the American Legion, the Masons, Elks and other fraternal orders, and belonged to the Morris County and the New Jersey Medical Societies and to the American Medical Association. Dr. Farrow served 3 terms on the Board of Aldermen and was a member of the Board of Education and the Zoning Commission.

His widow, the former Lydia Sharp, of Flanders, survives.

GARDNER, Dr. John Ward, husband of the late Carolyn Sands Merritt; father of John Merritt Gardner; son of the late Charles and Martha Post Gardner, died on Sunday, October 1, 1933, after a brief illness, at his home, 636 Ocean Avenue, Jersey City.

Dr. Gardner was born September 27, 1873, in what is known as the old Gardner Homestead on Second Street, Jersey City, which was built during the Revolutionary War. He attended public schools and the Hasbrouck Institute, Jersey City, and was graduated from Bellevue Hospital Medical College, New York City, in 1896. He opened an office at the corner of Grand and Warren Streets, Jersey City, in 1896, and a few years later he removed to 636 Ocean Avenue, Jersey City. He was a member of the Hudson County an the New Jersey State Medical Societies, also of Mt. Lebanon Lodge No. 46, Vermont, Free and Accepted Masons, delegations of which attended the funeral services at his late residence October 3, 1933. Interment was in the family plot, Arlington Cemetery, New Jersey.

Dr. Gardner was a thoroughly dependable physician. He was ethical, therefore, a gentleman. His genial personality, kindliness, honesty of purpose and willingness to be of service at all times, won him a host of friends who will greatly miss him.

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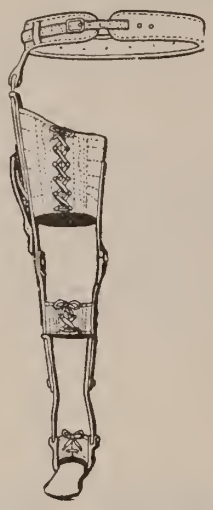
		Jan.	Feb.	Mar	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	
TEMPERATURE (Mean monthly—40-year average)		49.7	52.2	57.5	54.3	71.4	77.4	82.7	69.7	79.2	68.1	57.5	49.8	
RAINFALL (In inches—40-year average)		.8	.96	.81	.32	1.4	.23	2.4	2.46	1.0	.6	.76	1.09	Total 11.57
HUMIDITY Monthly (40-year average)	A.M.	61.	55.6	44.8	40.4	28.4	29.3	54.3	57.3	47.1	46.8	57.1	74.2	Aver. 49.5
	P.M.	35.3	27.7	22.4	22.6	15.9	17.7	36.7	35.7	29.0	26.5	41.1	48.1	29.9

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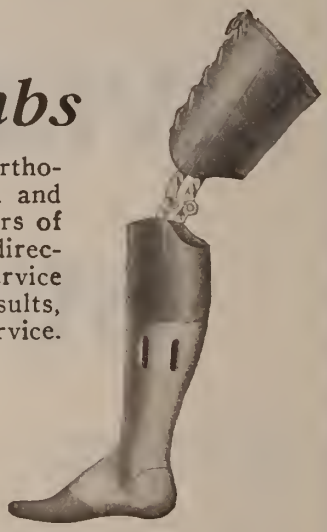
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THE VINEGAR OF THE 4 THIEVES

By Charles H. LaWall,

Dean of the Philadelphia College of Pharmacy and Science, author of "Four Thousand Years of Pharmacy"

One of the eighteenth century glass stoppered shelf bottles in the ancient pharmacy of E. R. Squibb & Sons, exhibited this Summer at the Century of Progress Exposition in Chicago, is labeled *Acetum Bezoardicum.*

Now, this name is unintelligible and untranslatable to the average member of either the medical or the pharmaceutical profession.

If one who is curious takes the trouble to look up the meaning of the word "bezoar", he will find that it applies to a concretion or calculus found in the intestinal tract of certain kinds of animals, particularly the herbiverous, and that it was once highly esteemed for its antidotal virtues.

If one consults a medical or pharmaceutical authority of the eigheenth century or earlier on the subject of bezoar, it will be found that the faith in the efficiency of this drug was so strong that it was believed that 'no poison, no eruptive, pestilential or putrid disease, could resist its influence".

Satisfied with this definition, the average investigator would dismiss the subject at this point with the assumption that *Acetum Bezoardicum* was a preparation of bezoar in vinegar (*acetum*). But there is a much more interesting tale connected with this name and with this preparation.

It is, in reality, made from aromatic spices and garlic. extracted with vinegar, and no "bezoar" entered into its composition at all, but the adjective "bezoardic" was intended to have a generic meaning of *antidotal,* as applied to this particular preparation, but to no other, for there were a number of preparations into which bezoar actually entered as an ingredient in the days when it was held in high repute.

If the searcher looks still further, he will find that it was called *"Gewürz Essig"* (spice vinegar); "Pest Essig" (plague vinegar); *"Acetum Prophylacticum"* (prophylactic vinegar), and *"Vinaigre des Quatre Voleurs"* (vinegar of the 4 thieves), and that it had a most unusual history.

The story told of its origin is that during an epidemic of "the plague" in Marseilles in the early part of the eighteenth century, 4 robbers, by the use of this prophylactic, attended without harm hundreds of dead and dying citizens, and under the guise of these disinterested services they robbed their victims; and that one of them being caught confessed their crimes and saved himself from punishment by divulging the composition of the preventive they had employed to pursue their nefarious practices.

The belief in this fanciful tale was so strong that the preparation soon attained a wide sale in both Europe and America and this sale continued for more than a century.

The interesting part of the story is that a modified form of this same remedy is still official in the National Formulary of the United States and in a number of foreign pharmacopoeias as well, under the name of Aromatic Vinegar.

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"The vitamin D tests also reveal the relatively high value of Newfoundland oil." "The northern fish grow more slowly than those frequenting the southern shores" (e. g., Newfoundland—due probably to the warmer temperature of the Gulf Stream) —from The Relative Values of Cod-Liver Oils from Various Sources, by J. C. Drummond and T. P. Hilditch.

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*(J. Soc. Chem., Ind., 1923, 42, 185, 205.)



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That this is so, has been demonstrated by many clinical tests on large groups of babies as well as by the experience of physicians with innumerable individual cases. Of particular interest is a recent study by Jeans and Stearns (Am. Jour. Dis. Childr., 46:69, July 1933) showing that the retentions of nitrogen, calcium, and phosphorus by infants on evaporated milk are approximately the same as those of infants fed on undiluted acidified fresh milk.

Evaporated milk, says Tobey in his new book, "Milk, the Indispensable Food" (Olsen, 1933), is the most digestible form of milk; this author also points out that the important vitamins A, D, E, and G are not appreciably affected when milk is evaporated, although there may be a slight loss of vitamin B and destruction of vitamin C. Since these vitamins are easily replaced in the diet by the supplementary foods routinely given to all babies, such as orange juice, this slight loss is of no practical significance and is more than compensated for by the many other advantages of a product such as Borden's Evaporated Milk.

HERALDS OF HEALTH

"We keep our Christmas merry still." Less money has been spent for gifts during the lean years since 1929, but every Christmas Eve Santa Claus has come down the chimney, holly wreaths have hung in the windows, Christmas trees have been lighted and the lucky folks with jobs and money in their pockets have shared their holiday cheer with their less fortunate neighbors. These good people have not forgotten to buy Christmas Seals to finance the work of the 2,000 tuberculosis associations in the United States. They even sent extra contributions when they could to make up for the folks who, perhaps for the first time, were not able to do their part. So, thanks to their generosity and loyalty, there have been funds available to continue the nursing, clinic, and educational programs more necessary than ever in these times. To be sure, the sum realized from the seals is only about ⅔ of what it was 4 years ago, but the devotion and resourcefulness of workers have made it suffice.

The design of the 1933 seal is symbolic of the "new deal", which all are hopeful will come for the Christmas Seal and all of us, with the New Year which the holiday season heralds. A group of medieval retainers are bringing the Yule log to the manor house to light the fires of good cheer for the Christmas feast.

The stamps sell for only a penny apiece, but the sum they raise is the "back log" of the fire which must be kept burning if one of mankind's oldest enemies is to be destroyed and the health of the nation maintained. They are sold by tuberculosis and health associations in every county in New Jersey.

LABORATORY TECHNICIANS TO DISCUSS ENDOCRINOLOGY

(Newark Evening News, Oct. 7)

The New Jersey Society of Clinical Laboratory Technicians met Wednesday, October 4, 1933. Committees were appointed. They were: Membership, David J. McKinnon, Chairman, and the Misses Mary Louise Weakley and Margaret Harris, all of Newark; Publicity, Mrs. Elizabeth Kauderer, of Camden, Chairman, and the Misses Margaret Kirby, Jersey City; Lallie Lancaster, New Brunswick; Margaret Doremus, East Orange; Phyllis Stanley and Lillian Baeder, Newark; Cecil H. Gowan, Glen Ridge, and Irving Salton, Perth Amboy.

Paul C. Brown, of Beth Israel Hospital, presided.

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	Term expires
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	Term expires
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	Term expires
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Herschel Pettit	1936
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William J. Sweeney	1938

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	Term expires
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William D. Olmstead, Atlantic City	1936
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	Term expires
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Ephraim R. Mulford	1936

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	Term expires
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William W. Brooke	1935
Arcangelo Liva	1934
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GROUP PAYMENT PLANS NOT AUTHORIZED BY PRESENT INSURANCE LAWS

(A. M. A. Journal)

A group payment plan for hospital care recently proposed by several hospital organizations in New York constitutes insurance and cannot be established under the present insurance laws, State Superintendent George Van Schaick has ruled. In view of this opinion, advocates of the plan will carry on further study and seek appropriate legislation at the next session of the Legislature, according to an announcement from the United Hospital Fund. The proposed group payment plan was worked out by a committee representing the Hospital Conference of the City of New York, hospital superintendents and the United Hospital Fund. It provides for the formation of a non-profit membership corporation to be known as the Associated Hospital Service of New York, which would be controlled by 10 directors. These directors would be chosen by the Presidents of the Hospital Conference of the City of New York, the Brooklyn Hospital Council, the 5 county medical societies of Greater New York and the Medical Society of the State of New York and the Trustees of the United Hospital Fund. The corporation would solicit members among employed groups at a rate of 90 cents a month or $10.80 a year, to be deducted from their pay, which would entitle them to 3 weeks of "semiprivate" hospital care during the contract year after a waiting period of 10 days (except in case of accidents) and a 10 months' waiting period in obstetric cases. Admission to the hospital would be granted only on the recommendation of the member's personal physician, and the patient would make his own arrangement for his fees for medical service. The corporation would reimburse the hospitals at a flat rate, which the committee hoped would eventually be $7 a day. Members of the committee studying the plan are Dr. Sigismund S. Goldwater, Chairman; Dr. Thomas Dwight Sloan, former President of the Hospital Conference; Louis I. Dublin, Ph.D., Third Vice-President, Metropolitan Life Insurance Company; Dr. Alexander Lambert; Karl Eilers, President, Lenox Hill Hospital; Rev. Joseph Brophy, representing the Brooklyn Hospital Council; George A. Wilson, attorney for the United Hospital Fund; Henry C. Wright, hospital consultant; and Homer Wickenden, Director of the United Hospital Fund.

COMMENDS NEGROES FOR HEALTH WORK

(Newark Evening News, Sept. 28)

The Negro is helping to improve health conditions among his race through the Negro Advisory Committee of the Essex County Tuberculosis League, Dr. Henry H. Kessler, President of the League, told the committee at its first Fall meeting at Kenney Memorial Hospital.

In the absence of Dr. W. G. Alexander, committee Chairman, the meeting was opened by Dr. Thomas Bell, of the Tuberculosis Division of the Newark Health Department. Dr. Kessler stressed the seriousness of the Negro health problem in Newark, but congratulated the group on progress during the year.

Activities reported by committee chairmen included opening of a clinic in Morton Street School with the coöperation of the Board of Education and the Health Department, food demonstration in Newark baby-keep-well stations, educational motion pictures and health talks in community centers and churches, special clinics and the observation of Negro Health Week.

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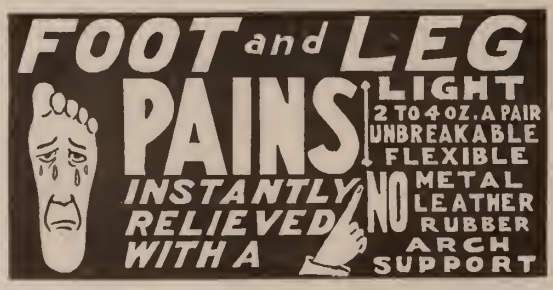
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OF THE

Medical Society of New Jersey

PUBLISHED MONTHLY UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION
OFFICE OF PUBLICATION, 14 SO. DAY STREET, ORANGE, N. J.

Entered as second-class matter, Sept. 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Sec. 1103. Act of Oct. 3, 1917, authorized July 29, 1918.

Vol. XXX., No. 12 Orange, N. J., December, 1933 Subscription, $3.00 Per Year Single Copies, 30 Cents

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ADDRESSES MANY GATHERINGS

Dr. Wells P. Eagleton, of Newark, New Jersey, returned recently from Omaha, Nebraska, where he was one of the honor guests of the Midwest Clinical Society at its annual meeting of physicians of the States of Nebraska, Iowa, Kansas and Missouri.

On Thursday morning, November 2, he addressed an assembly of physicians on his specialty. In the afternoon he conducted an open clinic and in the evening at an open meeting, attended by over 1000, he spoke on "The Immediate Past and the Immediate Future of the Practice of Medicine in a Large Eastern City". He reviewed the activities of the Medical Society of New Jersey in the past and outlined the plans for legislation in the interest of the doctors which are now being espoused by the President of the Medical Society of New Jersey, Dr. Frederic J. Quigley, of Union City, New Jersey.

He stated that, in his opinion, the 2 great elements for the betterment of the country were the Women and the Medical Profession, as they are supplying disinterested, intelligent leadership, and called upon all doctors to enter actively into poli-

Continued on Page XX.

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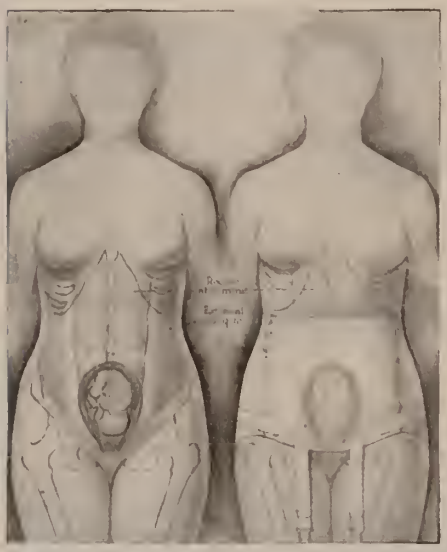
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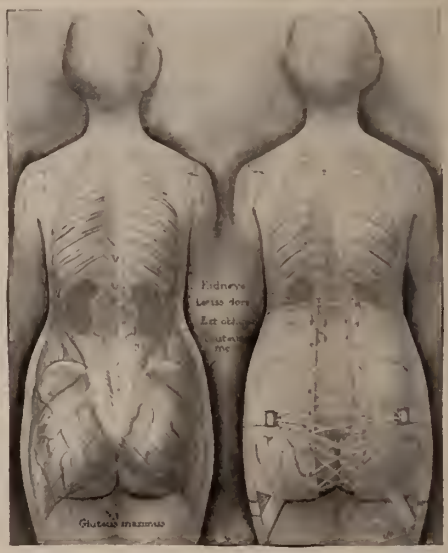
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Vol. XXX., No. 12 ORANGE, N. J., DECEMBER, 1933 Subscription, $3.00 per Year Single Copies, 30 Cents

Editorials

HYPNOTIC DRUG REGULATIONS

It is unfortunate that some of the most valuable drugs in our materia medica have a tendency to be habit-forming. The opium and coca derivatives are in this class, and their prescribing and dispensing has been strictly regulated for years. More recently, the derivatives of barbituric acid and other hypnotic and somnifacient drugs have been found to exhibit habit-forming tendencies. This merely bears out the importance of restricting the administration of all drugs to proper medical supervision. The most useful medicament can be made harmful by abuse and by indiscriminate employment without medical supervision.

Cognizance has been taken of the increase in self-medication with sedative, hypnotic and somnifacient drugs. Undoubtedly some of this increase is due to the failure of the medical profession properly to prescribe these drugs instead of asking their patients to obtain them under the various trade names of different manufacturers. Once a patient has been told to buy a package of Luminal, Allonal or Ipral tablets and obtains relief by their use, it is absolutely contrary to human nature to expect him not to purchase more of the same medicine when afflicted with what he may consider to be the same ailment.

The habit-forming effect of barbituric acid compounds and derivatives, such as sulphonal, trional, tetronal, carbromal, and of such preparations as paraldehyde, chloral hydrate, chlorbutanol and similar products, has reached such proportions that there has been a demand for some restriction of the promiscuous use of these products. New Jersey has taken a distinct forward step in being the first State to curtail the harmful effects of these drugs by requiring that they be dispensed only upon prescriptions of duly licensed physicians, dentists or veterinarians.

On June 21, 1933, Governor Moore approved Chapter 279, P. L. 1933, which makes it unlawful for anyone to sell at retail or dispense to any person any barbital or other hypnotic or somnifacient drug, as defined in the Act, except upon a prescription. Such a prescription must be compounded by a registered pharmacist or under the immediate personal supervision of a registered pharmacist. Dispensing of these drugs to their patients by physicians, when in their judgment this is deemed advisable, is permitted. However, a record of the date, the character and quantity of the drug dispensed and the name and address of the patient, must be kept by the physician.

It is important for physicians to bear in mind that a patient supplied with a prescription for any of these drugs may ask the pharmacist to renew such prescription. In the absence of any indication on the prescription that it shall not be renewed, the pharmacist has no recourse other than to renew it, as renewal of such prescriptions is not prohibited by the Act. There are many cases in which continued use of the drugs in question is expected and, in fact, is necessary. In such cases there is no

objection to renewal of a prescription. However, if the physician does not want his patient to obtain a further quantity of the same medicine without consultation, he should write on the prescription the words "not to be renewed". This order will be honored by the pharmacist and will be a safeguard to the patient in cases where continued use of the prescription is not desired.

A complete list of the United States Pharmacopeia, National Formulary and proprietary drugs coming under the restrictions of the Barbital Law will be printed in a future issue of the Journal.

Robert P. Fischelis,
Secretary and Chief Chemist of the Board of Pharmacy, State of New Jersey.

THE COMPENSATION LAW IN RELATION TO THE PHYSICIAN

The Compensation Law of New Jersey under which, by Legislative Act, the employer is responsible for the payment of compensation for injury or disease contracted during employment, was originally passed in 1911. It has been amended on several occasions so as to clarify the administration of the Act and, also, for the purpose of not only curing the disabled, but aiding in the prevention of accidents or occupational disease in industry.

The Act now provides that the employer shall furnish such medical, surgical and hospital services as are necessary to cure and relieve the injured workman of the effects of the injury, and to restore function to an organ or limb wherever restoration is possible. This obligation, without being specifically stated in the Act, has given the right of selection to the employer or to his agent, the Carrier.

The Carrier's basic opposition is the presumption that the average general practitioner is not competent to treat injuries or disease occurring in the course of one's employment. The Carrier contends further that the cost of a given case, when treated by a physician in general practice, is increased beyond the costs of the treatment rendered by a physician engaged by them. It is quite apparent that the latter contention is the more important one in their estimation.

The argument that one must be an industrial surgeon to treat these cases is as untrue in actual experience as the presumption that a surgeon, to treat battle casualties, must be a specialist in Military Surgery. The records of the War Department at Washington show that the number of qualified military surgeons available in the United States at the outbreak of the War was so small as to make the whole contention ridiculous. It is, further, quite evident to the medical profession that the title "Industrial Surgeon" is one that is generally associated with practitioners in the Compensation Bureau. It does not signify, as in other specialties, long and continued preparation and experience in a particularly limited field of surgery.

The Committee suggests, as a solution of this problem, (1) that the Carrier discontinue the treatment of compensation injuries or occupational diseases, and substitute a coöperative medical supervision; (2) that the Carrier select practitioners of the highest medical standing and experience, who, when a case is reported to the Carrier, will arrange for consultation with the attending physician and advise with him as to treatment. If, in a given case, opinions differ as to the advisability of transferring a patient to the care of an expert, or, where there is dispute upon other elements of treatment, or when no satisfactory agreement can be reached, it is suggested that these matters be referred for settlement to the present existing Medical Bill Committees now operating in the Compensation Districts. This is a method of solving the problem of "case lifting", and has received the support of the Medical Committee of the National Bureau of Casualty and Surety Underwriters.

The Workmen's Compensation Act as originally passed, provided only for Informal Hearings presided over by a Referee. The fact that the Referee is called upon to make a decision based entirely upon the medical evidence, necessarily created the demand for the appointment of a Medical Advisor or Referee

for the State. It is his function to examine the petitioner in the presence of the attending physician and the Carrier's doctor, and render an opinion as to the amount of disabiltiy existing. The Referee bases his determination upon this opinion, but no stenographic record is made of the procedure. The only report is that of the State physician made in writing to the Referee. The informality of these hearings and the lack of stenographic records have created much dissatisfaction and considerable publicity. It is hoped that the Legislative committee now investigating the Compensation Law will recommend the improvement of this procedure and the elimination of unsatisfactory conditions.

The amendment to the Act in 1918 provided for the appointment of Deputy Commissioners of Labor, whose function it is to preside at Formal Hearings. This created a Judicial Tribunal with a definite judicial procedure. The Deputy Commisioners act upon an application by either party for a final determination of permanent physical disability.

There is only one legal propositon entering into any of these claims, and that is, whether the injury occurred in the course of the man's employment. All other questions are entirely medical. The petitioner is represented by counsel, who supports his application upon the testimony of the attending physician plus several opinion witnesses. Necessarily, this requires testimony of a similar character by medical men for the defense. The Deputy Commissioner, after hearing this testimony, is expected to make a decision based upon this evidence.

It must be apparent, after study of this Act, that an opinion by a counselor-at-law upon a medical question, without fundamental knowledge on his part, can only be in the manner of a compromise. In the opinion of the Committee, such adjudication should be determined by medical men rather than by lawyers. As a result of the elaborated procedure of the Formal Hearings and the great amount of medical testimony presented, there has been much unfavorable criticism of the medical profession. It must be quite clear that the need for this testimony is created by the contentions raised by the several attorneys who represent the parties in suit; the legal profession, therefore, should recive its fair share of criticism.

The Committee recommends as a remedy for these apparent judicial defects, that there be appointed in each compensation district, by the President of the County Medical Society, with the consent of the Commissioner of Labor, a Board of Medical Referees composed of practitioners of standing and experience of at least 20 years. During their services on the Committee, the Board members shall have no association, directly or indirectly, with any of the parties concerned. To the Board shall be referred all disputed claims for disability. This Board shall hold sessions at designated times, shall hear the statements of the attending physician and such consultants as were associated in treatment of the petitioner, and the testimony of such physicians as examine the petitioner for the Carrier. At the conclusion of these hearings, the Board shall make an examination of the claimant, and render an opinion and report to the Deputy Commissioner. The report of the Board shall constitute the medical evidence in the case.

Further, to protect the petitioner, it is recommended that the President of the State Medical Society appoint a Board of 3 members of similar qualifications to members of the Boards hereinbefore named, to act as a Medical Board of Appeal when requested by the Commissioner of Labor. This Medical Board of Appeal shall have the right to examine the petitioner as well as to study the record and report of the District Board of Medical Referees. The proceedings of the Medical Board shall be open except during the examination of the claimant. There shall be a stenographic record of the entire proceedings in each case, which, with the opinion of the Medical Board, shall constitute the record. In the opinion of the Committee, such a procedure should eliminate unnecessary medical testimony, should relieve the present judicial officer from rendering a medical opinion and should be of manifest benefit to all parties concerned.

The Sub-Committee on Compensation of the Welfare Committee urges the several com-

ponent societies to coöperate in the study of these recommendations, and to give their collective aid to the Welfare Committee and the State Society in order to obtain such changes in the procedures and administration of the Compensation Bureau as will make possible the improvements outlined.

David A. Kraker, M.D.,
Chairman, Sub-Committee on Compensation, Welfare Committee—Medical Society of New Jersey.

William H. Areson
Jack Blumberg
H. Roy Van Ness
Earl LeRoy Wood
} Committee Members

EMERGENCY MEDICAL RELIEF PROGRAM

The program for medical relief of the indigent by private practitioners of medicine has begun to function in many counties of the state. The county medical societies and the county relief directors have reached an agreement consistent with the principles laid down by the Medical Advisory Committee of the Medical Society of New Jersey and the State Director of the Emergency Relief Administration.

This *County* agreement as to fees to be paid, and procedures to be followed by both parties, *must be approved* by the State Medical Advisory Committee and the State Director of the E. R. A., before the necessary funds are made available to the County Director for payment of bills presented by the coöperating physicians in his County. These fees are determined on a basis of 1/2 to 2/3 of the average fees charged by the doctors in the County—not to exceed a maximum of $1 in the office and $2 for home calls. No mileage is allowed, and no added charges for night calls. It is recognized that the fee does not represent the value of the work done by the physician; rather, it is an honorarium to the physician. The doctor can not reasonably be expected to continue carrying the full burden of free medical care for the indigent as he has done for such a long time. This burden, which has increased constantly, is now almost unbearable. The fees paid under this plan merely reduce this burden.

To say that the plan is working smoothly at this early stage is somewhat optimistic. One can truthfully say that the plan itself is sound in concept and development. The scheme is workable as organized. *But it will work only to the extent that it is understood by both contracting parties and is carried out in good faith through ways and means adapted to local needs and conditions.* The results so far are encouraging to the members of the Medical Relief Committee of our State Society who have been charged with the responsibility for this difficult task. Progress attained will be shown by figures now being collected—in so far as figures can ever be regarded as reliable criteria of not merely quantity but also quality of medical service rendered.

The primary aim of this emergency relief for the indigent sick is to provide a widespread service by general practitioners of medicine. This should take care of the great majority of emergency conditions, at fees which will permit most of the people in need of such care but unable to pay for it, to secure service without delay.

The plan is economical, because it avoids much needless hospitalization with its high attendant cost. Hospitalization will be provided, however, in cases where, in the opinion of the attending physician, this is essential. Moreover, under this plan, services rendered to clinic or hospital patients will not be paid by the E. R. A. Drugs dispensed by the doctor, except in certain places where drug stores are not available, are included in the fee approved.

Many of the claims made for additional fees, viewed from the standpoint of value given, are really fair. But "value received" is not, and cannot be, the basis upon which this plan is to function. The costs would be prohibitive or else would make the service available to only a small percentage of those in urgent need of attention. The costs entailed in the plan as outlined may exceed the estimates made. Therefore, special services, for the present at least, can be authorized only by the Directors of the E. R. A. When more data are available, it may be possible to make accurate estimates of future costs.

Some legal obstacles have been met which hamper the more rapid development of the plan in certain places, but it is believed that these difficulties will be smoothed out in actual practice.

Regardless of other outcomes, the medical profession, through this experiment, will obtain experience in one form of organized practice of medicine. It will have an opportunity to determine its own capacity for conducting well-planned medical service under the auspices of County Societies, and in conformity with certain agreements which physicians have entered into voluntarily. The proponents of "State Medicine" seem to take for granted that the medical profession cannot, or will not, act in concert according to agreements made. They feel, evidently, that the profession must be *made* to operate as an organization, supervised and controlled by a governmental or other non-medical agency. This presumption can be shown to be unwarranted through the successful conduct of projects such as the one under discussion.

This is *our* project as well as an E. R. A. project. It offers opportunity to show to our critics that we have ability to organize and conduct medical service at reasonable cost, and of a quality that no other group can duplicate.

The following memorandum has been sent to all County Medical Advisory Committees:

For County Medical Advisory Committees

This is a memorandum to emphasize the necessity for some form of working agreement between the physicians of your county and the County Director of Emergency Relief.

If you have not already met with your County Director of Emergency Relief and mutually agreed upon a plan which has been approved in its entirety by the State Medical Society's Advisory Committee and the Emergency Relief Administration, will you give this matter your immediate attention?

The problem of medical care for patients approved by the Emergency Relief Administration Municipal Directors is perplexing and state-wide.

The administrative headquarters for the State Emergency Relief Administration suggested that a coöperative venture be planned, with the aid of a Medical Advisory Committee appointed by the Medical Society of New Jersey, to provide medical resources throughout the State for the indigent. This mutual plan was printed in the August issue of the Journal. It involves close coördination in each County, of the County Director of the Emergency Relief Administration and the Medical Advisory Committee appointed by the County Medical Society. The County Medical Society undertakes to provide proper care for patients authorized by the County Director. In emergency, the physician may treat the patient at once and obtain authorization from the County Director within 48 hours. Before funds are available to pay for service rendered, the following conditions must be met:

(1) An agreement between the Medical Relief Advisory Committee of the County Medical Society and the County Director for Emergency Relief must be drawn up and signed by both groups. Since this is a mutual venture, request for a meeting of the two groups can come from either side. It is advisable that this agreement be reached and signed as quickly as possible.

Any plan agreed upon by the County Director of Emergency Relief and the Public Health Committee of the County Medical Society should be based upon the policies outlined in the program prepared by the State Medical Society and the State Emergency Relief Administrators and issued under the date of July 19, 1933. Copies of this program have been sent to each County Medical Society. Additional copies may be obtained from the executive offices of the Medical Society of New Jersey, 137 East State Street, Trenton.

(2) Plans agreed upon in each County, after being signed by both parties to the agreement, should be sent to both State organizations for approval before being put into effect. When the plan has been *approved* by the State organizations named, copies should be distributed to all participating physicians in the County.

(3) The Medical Relief Advisory Committee of the County Medical Society should immediately provide a list of physicians who have indicated their desire to participate in the treatment of Emergency Relief Administration patients. This list may include any physician in the County who is duly licensed and in good standing; it should not be confined to members of the County Medical Society.

(4) The Medical Relief Advisory Committee should investigate cases in which the question of unethical or unfair practice is suggested and those in which the fairness or correctness of bills submitted might be questioned.

(5) The County Medical Society has full responsibility and disciplinary power in all cases of flagrant abuse by physicians of the opportunities afforded.

(6) Names of physicians coöperating in the care of Emergency Relief cases may be added to or removed for cause from the list of approved physicians in each County.

(7) Where work is done in more than one County, the physician's name should appear on the list of physicians in *each* County so that he may be eligible to receive payment from the Emergency Relief Admiinistration for services rendered to authorized cases in the County.

(8) The State Emergency Relief Administration has definitely declared that medical relief may be furnished as a special or single phase of relief to a family or to an individual.

(9) The Medical Relief Advisory Committee should keep in close touch with the County Emergency Director and should advise him upon request in difficult or perplexing problems related to medical service. The committee may act individually or collectively as consultants to the Director when he is in doubt as to the necessity for, or proper procedures to provide in, the care for any of his cases. The Medical Advisory Committee members may act in similar capacity to Municipal Directors upon request.

County Medical Societies are asked to consider the following questions at once:

(1) Has your County Medical Advisory Committee a working agreement with your County Director of Emergency Relief for taking care of cases of illness to patients of the Emergency Relief Administration?

(2) If no approved agreement exists, are any negotiations under way?

(3) If negotiations are under way, when do you expect to be able to submit the plan for approval by your State Medical Society's Advisory Committee and the Emergency Relief Administration?

(4) If you have an approved agreement in force, please give date of approval by the State Medical Advisory Committee and the Director of E. R. A. in Newark.

(5) If you have an approved agreement in force, what changes have been made from the original proposal sent out by the State Medical Society's Advisory Committee?

Each County Society is urged to make a careful study of the aims and policies announced in the program mutually agreed upon by the Medical Relief Advisory Committee of your State Medical Society and the State Emergency Relief Administration. This will enable your County Medical Relief Advisory Committee to establish and conduct its procedures in conformity thereto.

A solution of many of the difficulties which arise during the early stages of putting your plan into practical operation is afforded by frequent discussion of the problems with the County Emergency Relief Director in an endeavor to provide working agreements.

Le Roy A. Wilkes, M.D.,
Executive Secretary.

ORIGINAL ARTICLES

RECURRENT VOMITING
A Clinical Study

F. I. Krauss, M.D., F.A.A.P.,
Chatham, N. J.

After the period of infancy, management of the child is frequently left to the limited knowledge of the mother. Little thought is given to constitutional factors, to proper rest, to mental and physical over-stimulation, and to all the details which help to decide the rate of growth in the childhood period. The fat, contented infant begins to change into a thin, active, nervous, mentally alert run-about. The mother, worried about the loss of weight and influenced by popular articles, urges the increased use of milk and cod-liver oil. The quart of milk becomes a fetish.

A certain number of these children develop what the old practitioner called "bilious spells" and what is now popularly called "acidosis". The most common symptom is recurrent and persistent vomiting.

Most of these patients are from 2 to 7 years of age, and have a history of periodic attacks of vomiting which recur at almost regular intervals. Some have the attacks every few weeks and some, every few months. The attacks vary much in severity; some patients vomit every few minutes, whether or not anything is taken by mouth, others vomit only a few times a day; the attack lasts from 1 to 5 days, the general average being 3 days. The fever is usually slight, the temperature, as a rule, not exceeding 101° and then not until the attack has persisted a day or two. Occasionally, in severe cases, one sees a temperature as high as 104°. The pulse is proportional to the temperature. Prostration depends on the initial toxemia; it is usually not severe at first, but manifests itself progressively as the vomiting and starvation of food and fluid persist. Most of the patients are bed-ridden, being content to lie quietly, manifesting no desire to get about until the illness is over. Persistent craving for water is present. Abdominal pain is usually secondary to the act of vomiting, and ceases soon after the attack is over. It is not a prominent symptom in the majority of cases. Severe cases may develop all the symptoms of acidosis with fever, air hunger, dry tongue, stupor, coma, and even death. Most patients can be relieved by proper treatment before danger of death supervenes.

The interesting factors in this condition are those of etiology. Very little is to be obtained from physical and laboratory findings. The clinician must use his best powers of history-taking and deduction. There is not difficulty in taking care of a child suffering from an ordinary attack; this patient will recover anyway. The dangerous attack is fortunately very rare. It is a travesty on modern medicine to call these attacks "bilious spells", "upset stomachs", "constipation", "acidosis"—to give a cathartic, an irrigation and some imaginary stomach sedative, and to think one has done his duty. A picture of the child beginning with hereditary traits, including dietetic history, environment, physical characteristics, and mental stress must be developed properly to understand the reasons for these periodic catastrophies.

There must be some constitutional reason why a child, who, up to 2 years of age could digest without difficulty 1 quart of milk per day and a high carbohydrate diet, now begins to have a periodic illness which usually can be prevented by omitting or reducing this type of food. However, this is not all there is to the case. To quote Dr. E. L. Richards in "Behavior Aspects of Child Conduct"—"Inferior biological development manifests itself in a variety of ways, such as prolonged bed-wetting, night-terrors, nail-biting; in mucous colitis, cyclic vomiting, easy fatigue, etc. Medical science knows little about these conditions, treating them symptomatically, guided here and there by protein sensitization, but science is coming to realize more and more that such symptoms indicate a nervous system organization which must be carefully steered through

the traffic jams of life. Prolonged physical exertion, strains of too great responsibility, environmental function which the average person meets with 'bracing up', cause these neuropathic individuals to bend and often to break."

The history of every case must begin with that of the parents. Is there a history of rheumatism, of migraine, epilepsy, asthma, eczema, intolerance of, or aversion to certain foods, particularly milk or eggs? Is one of the parents, especially the mother, a thin neurotic type? Particularly important are the symptoms of nervous imbalance. If there are other children, what is their constitution, both physical and mental? Were they subject to eczema, asthma, periodic bronchitis, or recurrent vomiting?

It is a curious phenomenon that congenital dyscrasias disclose themselves at various ages, pylorospasm and eczema during the first year, spasmodic croup during the second, asthma approximately in the third or fourth, cyclic vomiting from the third to the seventh, so-called idiopathic epilepsy in late childhood or early puberty. Why do certain eczema cases which are excited by an allergy to milk subsequently develop asthma which is not influenced by removing milk from the diet? Why do many children suffering from vomiting thrive on a fat-free diet, when as infants they could take 32 oz. of milk without disaster? Certainly there is some under-current of metabolic dysfunction which dates from birth and which is an inheritance of something wrong in the family strain. That is the reason I place emphasis on a careful family history before making a prognosis or giving treatment. I have personally encountered this difficulty in caring for these cases in adopted children, where the hereditary factors are not known.

The immediate causes are those pertaining to diet, to the nervous system, and to physical fatigue and imperfections. During the first year children are given an abundance of sugar, usually 1 to 3 oz., plus cereals during the second period of 6 months. After the first year it is customary to omit all sugar, most diets not even allowing it on the cereal. Effort is made to continue the quart of milk, besides adding butter and eggs and cod-liver oil. Frequently cream is also used. Particularly harmful is the use of Guernsey or Jersey milk. Also at this time children tire of cereals, and their quantity is markedly reduced; from some diets they may be entirely omitted. There is consequently an increase of fat in the diet relative to the feeding of the first year. The vegetable, fruit, and bread feedings do not by any means furnish as much carbohydrate as the infant was accustomed to. As the weight shows a tendency to become stationary, or to progress slowly, more and more emphasis is placed on milk and cod-liver oil. Milk is given between meals and at school. It is not unusual to obtain a history of the onset of the illness at the school age when the nurse advises extra milk. Much harm has been done by placing too much emphasis on height and weight records and on nutrition classes without regard to the individual constitution.

The great majority of these children are of the thin, energetic type who normally eat little and sleep little. They have poor appetites, have been coaxed since infancy to eat, and have an aversion to bulky, plain foods. They dislike cereals, and vegetables in particular. The more they are coaxed to eat the worse they become. The afternoon rest has usually been abandoned because the mother finds it almost impossible to keep the child quiet; to put it to sleep is entirely out of the question. If put to bed early in the evening, the child either lies awake a long time, or awakens early in the morning. In either case his hours of relaxation are much curtailed. During the day these children are constantly in motion. They have alert, restless minds. They suffer from a state of continuous over-excitation with shortened periods of rest resulting in nerve fatigue.

Physical imperfections pertain largely to congenital ptosis of the stomach and colon. X-ray series show that some patients have a dilated, ptosed stomach with a sagging transverse or redundant colon. In these instances delay in the emptying time of the stomach, with an accompanying constipation may result. Relaxation of the abdominal muscles with a protuberant abdomen, lumbar lordosis and flattened chests with a low diaphragm further aggravate this congenital weakness. Often, when it is not feasible to take x-ray pictures, the posture alone will give a working clue to

the intestinal condition. Another physical imperfection is diseased tonsils. The removal of these not infrequently cures the child. One should be on guard against being misled by secondary rather than primary throat infections. After a child has been vomiting for a few days, he sometimes suffers from a pharyngitis with swelling of the tonsil tissue. This differentiation is important because the doctor may be embarrassed later if he promises too much from tonsil operations. The importance of chronic appendicitis in young children is open to discussion; equally good men are divided in their opinions.

Hereditary imbalance, decreased consumption of carbohydrates, relative increase in fats, physical and mental overstimulation, pathological conditions, all contribute to form the background of the acute disturbance.

The immediate causes of attacks are nervous and physical fatigue, acute infections, and specific errors in diet. Children's parties, picnics, etc., are common reasons for an attack. Fatigue from hard play, especially in the heat of the summer, will precipitate trouble. Any acute infection may be accompanied by more vomiting and prostration than is usual for that condition. Errors in diet include eating a hearty meal when tired, especially in the evening; too much milk, cream, butter, egg, or sugar at one time. Whereas the normal child, having vomited once or twice, would be well the next day, the children in this group develop a real illness. I am not making the usual error of putting the emphasis on constipation. If the diet is balanced, a little constipation is not likely to do much harm. The pathologic case of constipation from my viewpoint is one due to a ptosis of the colon; a little delay in the sigmoid is of comparatively little importance. I have been led to this belief because of the almost universal history of the constant use of laxatives, physics, and enemas, without benefit, and by the observation that children who are entirely neglected in this respect get along as well, if not better, than those repeatedly purged.

The method of treatment is dependent on an analysis of both predisposing and exciting causes. Prophylaxis must take into consideration the heredity and the constitution, particular stress being laid on the necessity of conserving energy. One cannot reiterate too often the fact that these children are usually tired children, that unless they are rested they will have recurrences in spite of everything. They need a period of relaxation at noon and long hours of sleep at night; sedatives should be given if they are necessary to induce sleep. Many need small daily doses of phenobarbital. Excitement of all types must be avoided: parties, moving pictures, and long automobile rides should be forbidden; if necessary school should be restricted to a half day, and no extra-curricular activities such as dancing and music lessons should be permitted. I appreciate the fact that we are asking for ideal control, but the nearer it is approximated the more normal will be the growth of the nervous system.

The importance of the gastro-intestinal series needs to be mentioned again. This work is not done in children as often as it should be; when properly performed it reveals many interesting abnormalities, and discloses them at the time of life when treatment is most satisfactory. The necessity for the removal of infected tonsils is self-evident. Time and again we see cases in which the removal of tonsils, by stopping acute attacks, has been sufficient to change the picture entirely. This will not occur if other factors also are at fault.

When the exciting cause is poor fat metabolism, the correction of this results in an immediate improvement. The majority of my cases come under this classification. These patients have a low tolerance for fat, and have not been fed enough carbohydrate. In the treatment of these cases we begin by eliminating fat altogether for from 1 to 3 months. The milk should be fat-free or skimmed; no butter, animal, or vegetable fats are allowed. When the cycle has been broken, and when the child has not had a vomiting attack within the period in which they usually occurred, we begin to give him small amounts of fat, increasing slowly until we reach the normal balanced diet, if possible. Holstein milk is better than Guernsey or Jersey milk. The variation in the amount of fat allowed will differ in each case. We usually find that most patients can take 16 oz. of milk, especially Holstein, plus

moderate amounts of butter and an occasional egg. Raw milk or pasteurized milk is used, as children dislike boiled milk. Many gain in weight, have a good appetite, are less subject to fatigue and are clinically cured. It is gratifying to see how well they eat normal quantities of vegetables, fruits, and cereals. They do not seem to be harmed in any way by the temporary reduction in fats, nor are they more subject to infections.

By this method we have accomplished 2 important things. First, we have educated the mother in the proper handling of the child's diet. She no longer thinks in terms of pounds but in terms of health. Second, we have given an overstrained organism a much needed rest, and a chance to build up gradually a tolerance normal for it as an individual.

Medicines are seldom given, for we have not found them necessary. Cascara seems to be the best drug for constipation; it is given in divided doses after each meal, enough being administered to cause 1 or 2 daily evacuations. Alkalies after meals are occasionally used.

The purpose of treatment is to remove physical and dietetic strain from a biologically weak organism. If we could prevent these children from being over-stimulated physically and mentally, if we could return to the régimé of the infant with nothing to do but eat and sleep and play, these attacks, I believe, would not occur. It is practically impossible in most families to give these children the proper environment; their parents expect them to grow too fast for their individual constitutions, and they must maintain their school and social activities. We already have a condition of fatigue. When we cannot remove the reasons for the fatigue, we remove as far as possible exciting causes which come within the range of the cooperation obtainable.

The treatment of the acute attack depends on its severity. The majority clear up in from 1 to 3 days without any danger. An initial colon irrigation is of value. Cathartics increase the dehydration and retard recovery. The promiscuous use of gastric antacids and sedatives is wrong therapeutics. The vomiting is toxic; it is not due to local irritation. A very efficient treatment is phenobarbital sodium by hypodermic injection or by rectum. It is absolutely useless to give anything by mouth; fluids, foods, and medicines will be vomited until the toxin which causes the vomiting has been neutralized or excreted. This requires a certain moral courage on the part of parent and doctor. It is best not to give anything by mouth until there has been no vomiting for at least 6 hours. This is ultimately doing the patient a kindness in spite of his entreaties for fluid. When fluids are first administered, do not begin with orange juice or milk, for they are very likely to start the vomiting all over again. Use either normal saline, sweetened tea, or a mild alkaline water, beginning with teaspoonful quantities. Later, gruels and vegetable purees can be used, followed finally by fruit juices and skimmed boiled milk.

A certain number of cases progress until the acidosis may be dangerous to life. Fatalities occasionally occur. When the tongue becomes dry, the subcutaneous tissue flabby, restlessness increases, temperature, pulse, and respiration rise, it becomes extremely important to get fluids into the system directly. The secretion of urine must be stimulated. At present, our best method of producing diuresis is the use of normal saline by hypodermoclysis, by intraperitoneal injection, or by intravenous injection. Five per cent glucose with saline intravenously is valuable. The number and type of these treatments are determined by the evidence of restoration of kidney function as measured by the amount of diuresis. Hypodermocylses of normal saline will be sufficient in most small children; they are easy to give and entail little pain and no danger. One hundred to 200 c.c. can be given every 4 hours. According to reports, glucose should not be given intraperitoneally unless specially prepared for this purpose; otherwise severe reactions may result. The intravenous injection of 4% bicarbonate of soda is advised by some and condemned by others. Whatever method is used, injections of fluids are often life-saving measures, success depending on their frequent use until all danger is over. When one has seen children die from toxemia, every case is watched with concern until fluids can be retained by mouth. The patient can become moribund in a few hours.

Conclusion

I am not discussing the limited knowledge we possess about acidosis, ketosis, acetonemia, or other laboratory data. These theories are of little help to the clinician treating recurrent vomiting in his private practice. I do not think they touch the actual reason for the condition. These patients are seldom hospitalized unless they become seriously sick. I am trying to develop a picture of a typical problem of private practice, in which the child must be studied as an individual. These cases belong to the general practitioner.

Recurrent vomiting in childhood, according to the writer's experience, is usually of a neuropathic origin, and should be treated primarily by a study of the constitution of the child. Avoidance of physical, and especially nervous, fatigue is most important.

Change in dietary habits with a reduction in the amount of pure carbohydrates and starches, with a relative increase in the amount of fats predisposes, in a certain type of child, to an accumulative, periodic toxemia characterized by persistent vomiting and prostration. It is most common in children from 2 to 7 years of age, and is seldom seen after 10. As the child grows older the mother becomes less insistent on the quantity of milk taken and more pure carbohydrates are allowed. This automatically corrects the tendency to recurrent toxemia which these patients possess. Other predisposing causes are physical defects in the intestinal tract, and chronic infection, especially in the tonsils.

Attacks are precipitated by acute infections, and by physical and mental exhaustion.

Treatment of the metabolic imbalance by reduction in the fat and an increase in the carbohydrates will clinically cure the majority of the cases. The acute attack, if severe, demands the liberal injection of fluids, preferably normal saline or glucose solutions, until vomiting is controlled and diuresis well established.

Discussion

Dr. Thomas P. Prout: In going into the childhood factors that have to do with the development of epilepsy, I have been impressed by the particular bearing that this condition has upon the genesis of this disease in later life. I have seen a large number of cases of that character. At the moment I think of a case of that type giving a story of a very difficult childhood with gastro-intestinal disturbances recurring without known cause and coming on at longer or shorter intervals, culminating in periods of persistent vomiting. The case blossomed out later with epileptic attacks. This sometimes follows shortly after puberty or it may be deferred to the third or fourth decade of life.

There is one factor which enters into the etiology of these cases that I consider very important to bear in mind. Of course, it is well known that we often see epilepsy develop upon the hereditary basis of a dipsomaniac trend in one or both parents. I know of a case in which cyclical vomiting in infancy or early childhood was founded upon that kind of hereditary basis. It is well to bear in mind this manifestation of periodicity—this uncontrolable recurrence of neuropsychiatric breaks of an alcoholic character at given periods of weeks or months—when we are looking for an etiological factor in these cases. Upon an heredity of this type we may get a child with cyclic vomiting and later in life an epilepsy. In the case of a woman whose father was a dipsomaniac, this trend showed itself in the daughter in the form of an inordinate desire for candy at longer or shorter intervals and in her daughter as cyclic vomiting.

Dr. F. W. Lathrop: I have been very much interested in this excellent discussion upon a subject that is so commonly found in practice and in the types of patients that we are meeting constantly whom we must be careful in treating. Dr. Krauss' emphasis on the neuropsychiatric constitution is very interesting. I was disappointed that he did not mention the hypoglycemia which the children frequently show at the onset of an attack. I personally feel that the administration of glucose is as important as the administration of fluids and think that we should attempt to start this treatment at the earliest possible moment. I feel that these patients do retain minimal amounts of glucose by mouth given in cracked ice or teaspoonfuls every 5 minutes; in the more severe cases it should be given per rectum after the colonic irrigation. In these children with a high fat diet and a tendency to develop hypoglycemia with abstinence from food for any cause, or in the case of the beginning of vomiting brought on by some dietary indiscretion or by fatigue, I feel that we can frequently help to prevent these attacks not only by regulating the diet but by giving them additional glucose daily—perhaps in orange juice, in the middle of the afternoon. I frequently find, in these neurotic children, that this treatment seems to help quiet down their fevered brow throughout the school year. The mother generally has a slight warning of the beginning of an attack. She has learned that the child becomes restless and irritable and overtired; these symptoms she recognizes often as begnning from 1 to 2 days, or even just a few hours, before the attack. By instructing her to give them mild alkalies and glucose at the beginning of these warning symptoms, it is frequently possible to prevent the development of actual vomiting. After carrying the child along in this manner, the attacks of vomiting gradually become less frequent and finally disappear.

CARCINOMA OF THE SMALL INTESTINES*

S. A. Goldberg, Ph.D., M.D.,
Newark, N. J.

Introduction

Carcinoma of the small intestines, according to the literature, is a rare condition. One reason for its apparent infrequency is the difficulty in diagnosis, particularly the difficulty of interpreting the roentgenogram of the small intestines. With added experience in clinical, as well as x-ray diagnosis, it is possible that more cases will be brought to our attention. Since 1930 a larger number of cases have been reported, most of them carcinoma of the duodenum. This is the most common seat of malignancy in the small intestines.

Congenital anomalies, especially diverticula, occur commonly in the duodenum, particularly in the region of the ampulla of Vater. The duodenal site, embryologically, is the anlage for the pancreas on the left and the liver on the right, so that tumors of both the pancreas and the liver may be considered as originating upon a duodenal basis; in fact, carcinoma of the duodenum from pancreatic cells has been described.

Carcinoma of the duodenum is reported as constituting 4% of intestinal carcinomas. Of that number 15-20% are parapyloric, 60-72% peri-ampullary, and 7-12% prejejunal. Thus we see a relationship between the site of greatest frequency of congenital anomalies and the point of appearance of carcinoma, namely, the periampullary region of the duodenum. Here there are 6 possible points of origin: (1) From cells lining the ampulla; (2) from cells lining the common duct; (3) from cells lining the pancreatic duct; (4) from the duodenal mucosa of the papilla; (5) from Brunner's glands; and (6) from aberrant pancreatic acini in the wall of the common duct.

The symptoms of peri-ampullary carcinoma are pain and gradually increasing obstructive jaundice; in these cases a presumptive diagnosis of carcinoma of the head of the pancreas is generally made. Parapyloric carcinoma of the duodenum is said by some to originate from a previous duodenal ulcer. It occurs in the site at which duodenal ulcers are usually found. Prejejunal malignancy, or carcinoma of the third portion of the duodenum is extremely rare. Archibald states that no x-ray signs can be considered diagnostic of carcinoma of the small intestines.

Malignancy of the rest of the small intestines is even more rare than carcinoma of the duodenum, and definite statistical data are not available.

Cases

The following 4 cases have been encountered during the last 3 years in a comparatively small hospital. This incidence suggests that carcinoma of the small intestines is more common than the statistics would indicate.

Case I. H. R., a woman, 63 years of age, was admitted to the hospital complaining of jaundice, loss of weight, asthenia, and nausea. The past personal history was negative. She had been well up to 6 months before admission, when she was troubled with epigastric distress and flatulence, not accompanied by pain, but with considerable nausea, almost to the point of vomiting. She showed gradually increasing jaundice. During the last 6 months she had lost 30 pounds in weight and had become very weak. *Physical examination* showed an extremely jaundiced, thin, elderly woman, with negative findings except for a hemic murmur in a heart of normal size. Her temperature was 99.2° F., pulse was 85, respirations were 20. *Laboratory findings*: Urine showed bile, a few granular casts, and a few clumps of leukocytes. Urobilinogen and urobilin were absent. The hemoglobin was 44%, erythrocytes 2,710,000; there was moderate polymorphonucleosis; bleeding time was 8 minutes 30 seconds; coagulation time, 7 minutes; blood sugar, 102 mgms.; urea nitrogen, 12 mgms.; icteric index, 60; there was an immediate direct Van den Bergh reaction, bilirubin being 10 mgms. per liter. Stool was clay-colored, bile absent. *X-ray examination*: Gall-bladder was not visualized. Lateral views of stomach, in G. I. series, suggested a retrogastric mass producing a *slight concavity of the cap* posteriorly. The x-ray diagnosis was "pathological gall-bladder, possibly adhesions of ileum and a suggestion of an indefinite retrogastric tumor".

Presumptive diagnosis: Carcinoma of the head of the pancreas. *Progress*: During a rest period of 11 days with glucose and hydrotherapy, the patient had a "saw tooth" low grade temperature, which on 2 occasions reached 103° F. At the end of this rest period, a right upper rectus laparotomy was performed under ethylene anesthesia. The gall-bladder was found distended, the liver enlarged, with a nodular enlargement of the head of the pancreas obstructing the common duct. A cholecysto-duodenostomy was performed. The operation lasted 70 minutes; blood pressure: systolic 125, diastolic 52; pulse range 80-88, quality not

*(From the Laboratory of the Presbyterian Hospital, Newark, N. J.)

changed. The patient expired just as the wound was being closed.

Autopsy showed marked cerebral anemia which probably was the immediate cause of death. In the duodenum an oval crateriform ulcer, 3 cm. x 2 cm., was found involving the ampulla of Vater, ending abruptly at the edges. Histologic examination of the edge of the ulcer, and of the enlarged retropyloric and the lumber chain of lymph nodes, showed large columnar cells with atypical hyperchromatic nuclei in alveolar arrangement, invading a dense fibrous stroma containing lymphocytes, plasma cells and polymorphonuclear leukocytes. All of the bile and pancreatic ducts were extremely dilated. In the liver there was an infective interlobular cirrhosis and in the pancreas, a chronic productive and suppurative pancreatitis. The spleen showed a hyperplastic splenitis.

Case II. G. W., a woman 72 years of age, was admitted to the hospital complaining of nausea. The past personal and medical history were negative, except for pneumonia many years before admission. The present illness began a year ago, when she suffered from indigestion accompanied by the belching of a large amount of gas. Four weeks ago she developed anorexia and vomited almost every day; this vomiting bore no definite time relationship to meals. The vomitus, bile stained at first, subsequently contained some blood. The patient was constipated and lost weight. *Physical examination* showed a senile undernourished anemic woman with a systolic blood pressure of 160, a diastolic of 80. The stomach was dilated. There was marked tenderness in the epigastrium and hypochondrium. *X-ray examination* showed an obstruction of the horizontal portion of the duodenum with a 48-hour retention in the stomach, possibly due to adhesions or to a retrogastric tumor. There was an hour-glass contraction of the middle third of the stomach as a result of an old ulcer.

Progress: Seven days after admission, a laparotomy and duodeno-jejunostomy were performed, with a side-to-side anastomosis proximal and distal to the obstruction which was 10 cm. from the beginning of the jejunum. Her condition progressed satisfactorily for 5 days. On the sixth day she had a chill lasting 20 minutes. Her temperature rose to 105° F. She developed dyspnea, restlessness, cough, coarse râles in left upper lobe, and expired 9 hours after the chill.

Autopsy: Both pleural cavities were obliterated by old adhesions with bronchiectatic areas in both lungs, and a partly resolved pneumonic area in the right middle lobe. The right bronchial lymph nodes were calcified. The heart showed coronary sclerosis with chronic productive myocarditis. The stomach was of the hour-glass type, the cardiac portion being the smaller segment. The esophagus and stomach were distended by a bile-stained liquid. There was a whitish firm mass adjacent to the terminal portion of the duodenum, extending into the pancreas on one side of the mass, and adherent to the constricted portion of the stomach by a wide fibrous band on the other side. Microscopic examination of the duodenum adjacent to the mass showed invasion, by columnar cells containing hyperchromatic nuclei in irregular alveolar arrangement, of the muscularis, the subserous coat and the connective tissue of the mass. The pancreas, in this area, showed marked fibrosis, with atrophy of acini and dilated ducts. The islands of Langerhans stood out in the hyalinized connective tissue. The rest of the pancreas was normal. In the adjacent lymph nodes there was no evidence of any involvement. Other changes were focal embolic glomerulonephritis with nephrosclerosis and atrophic cirrhosis of the liver.

Case III. M. Z., a man 42 years of age, was admitted to the hospital with signs of cardiac failure; i. e., orthopnea, cyanosis, and anasarca. Rest and digitalis relieved him. After 3 months' stay in the hospital, he expired with signs of cardiac failure. The only signs referable to the gastro-intestinal tract were diarrhea and cachexia, the former attributable to the cardiac failure, the latter, to his chronic ailment.

Autopsy showed an extremely emaciated adult male with extensive cyanosis of the face, neck and body, and edema of the lower extremities. In the jejunum, at a point 70 cm. from the ligament of Treitz, there was an ulcerated area 15 mm. in diameter and 1 mm. deep, with an indurated base. About 20 cm. from this point toward the ileum there was an oval, firm mass of mesenteric lymph nodes 5 cm. long and 2.8 cm. in diameter. The liver was enlarged, extending about 4 cm. below the costal margin, containing 5 whitish nodules, each 8 mm. in diameter. The rest of the liver showed passive congestion. Histologic examination showed the edges of the ulcer composed of irregular large cells with hyperchromatic and polymorphous nuclei in cords, masses, and occasional alveolar formation invading a dense fibrous stroma. The lymphatic and hepatic metastases showed similar structures. The cause of death was cardiac failure (of a slightly enlarged heart) with polyvalvulitis.

Case IV. A man, 72 years of age, was admitted to the hospital suffering from acute intestinal obstruction. At laparotomy an intussusception of the jejunum was found, not far distant from the ileum. The mass was resected, an anastomosis of the intestine was performed, and the wound closed. The patient died of peritonitis, 72 hours later. Permission for autopsy was not obtained. *Examination of the tissue* showed a portion of jejunum 6 cm. long with a smooth sessile polypoid mass, 3 cm. x 5 cm. x 1.5 cm. projecting into the lumen. On section, it was firm and whitish in color. Histological examination showed large cells with hyperchromatic nuclei in cords and nests invading a dense fibrous stroma.

Comment

Case I is typical of *periampullary ulcerating adenocarcinoma* originating in the duodenal glands, with an early complete obstruction of the common bile and pancreatic ducts. The peculiar concavity of the duodenal cap seen in the roentgenogram is possibly typical of such a carcinoma of the duodenum.

Case II is an *alveolar adenocarcinoma* of the third portion of the duodenum, a rather rare site, with an adhesion producing an *hour-glass dilatation* of the *stomach*. The roentgenological findings were those commonly produced by ulcer and adhesions. The symptom of *nausea* is very common in neoplasms of the small intestines. The neighboring lymph nodes are not involved, as metastasis occurs late in this condition.

Case III is an *ulcerating, fibrosing carcinoma* of the jejunum. Although there were metastases into the mesenteric lymph nodes and the liver, the diagnosis was made only at autopsy. The patient had been carefully studied in 3 large hospitals in the metropolitan area during the preceding 2 years, but attention had been directed exclusively to his cardiac condition.

Case IV is a *fibrosing carcinoma* of the jejunum producing an *intussusception* which necessitated an emergency resection.

Summary

Four cases of carcinoma of the small intestines are recorded; 2 of these were in the duodenum, 1 in the second and the other in the third portion. Two were in the jejunum. In none of these cases, was a definite clinical diagnosis established. It is likley that with further study, carcinoma of the small intestine will be found to be more common.

DISCUSSION

Dr. Charles F. Baker (Newark): So far as I am aware, literature on this subject, "Lesions of the small intestines", is scanty and we are fortunate in having Dr. Goldberg's paper presented here today.

Demonstration of malignant or other tumors of the small intestines by means of the x-ray requires patience, the taking of repeated roentgenograms at short intervals, ½ to 1 hour over a considerable period of time, very rapid exposure technic, and careful study of the roentgenograms. This offers a serious economic problem and cannot be followed routinely in gastro-intestinal work. However, if the films are made with rapid exposure technic, we should be able to notice suspicious appearances in the ½, 2 or 4-hour films which are now made routinely and, if there is a question as to an abnormal appearance, the patient should be re-examined at ½-hour intervals for 3 or 4 hours subsequent to a second barium meal.

The roentgenologist has been so interested in the study of gastric and duodenal lesions, that he has paid little attention to the remainder of the small intestine. Recently, however, with better technical procedures, the appearance of the barium as it distends the small intestine or lies along the folds of the mucous membrane is being given more study.

The small intestines, like the stomach, consist of 5 coats from without inward. These are: (1) The peritoneal coat, (2) the circular and longitudinal muscular fibers known as the Muscularis Propria, (3) the submucous coat, (4) the muscularis mucosae, and (5) the mucous membrane.

In the stomach the muscularis mucosae assumes a prominent rôle in the formation of the peristaltic waves which run along the greater and lesser curvatures; the longitudinal and circular coats, on the other hand, are supposed to establish the general tone of the organ rather than to participate in the active propulsion of the food toward the pylorus. In the small intestines, however, the muscularis propria takes a more active part in peristalsis. The propulsion of the contents of the small intestine is undoubtedly the result of the action of 2 muscular forces, the muscularis mucosae causing the rugae formation and the strong contractions of the muscularis propria closing off an area and preventing reversal of the current or passage of the contents in a retrograde direction.

The mucous membrane of the digestive tract, excepting the cap or postpyloric region, sometimes called the bulbous duodeni, has a mechanical movement independent of the muscularis propria. This independent movement is solely the result of contraction and relaxation of the muscularis mucosae.

When the lumen of the small intestine is entirely filled with barium and when the shape has the more or less typical cylindrical outline or sausage form, the borders are straight or almost so, and we do not find the fine linear markings of the mucosal pattern because they are obscured by the large amounts of opaque medium. When, however, the lumen is partly empty, the shadow of the small intestine is rough and serrated and the rugae can be well differentiated. At this time, study of the so-called mucosal pattern produced by these rugae may reveal the presence of irregularities due to pressure upon the rugae from growths projecting into the lumen or from actual ulceration of the latter.

Forsell, of Stockholm, and Cole, of New York, have arrived at different conclusions regarding the mechanics of movement of the mucous membrane although they record similar observations. Briefly, Forsell believes that the mucous membrane of the digestive canal is a plastic organ which has an independent mechanism of movement and he believes the mucous membrane is modeled according to the needs of digestion and that in neither stomach nor intestine are there any permanent folds. Cole believes, "the mucous membrane, excepting that of the cap, has a mechanical movement independent of the motion of the muscularis propria, this being solely the result of contraction and relaxation of the muscularis mucosae. In the stomach, an annular progressive peristaltic contraction of the muscularis mucosae, which is firmly fixed to the mucosa, causes the peristalsis which one sees fluoroscopically, roentgenologically, or roentgeno-cinemato-graphically. This statement does not apply to the firm concentric periodic closing of the pyloric canal. The muscularis mucosae does not cause a wriggling or any other movement of the rugae excepting that the rugae are slightly altered in shape and position by each progressive peristalsis as it passes pylorus-wards. The mucous membrane folds in the small intestine, called the valvulae conniventes, are fundamentally different from the rugae in the stomach. They should not be compared with the rugae of the stomach, at least so far as motility is concerned. They are comparable with gastric peristalsis and the plica angularis. The valvulae conniventes are mucosal folds which cause the characteristic mucosal pattern of the small intestine. They have a movement which is not caused by the muscularis propria but, at times, is altered by it. The movement of the valvulae conniventes is one which progresses cecalwards and it is the function of the muscularis mucosae and not the muscularis propria which sweeps the intestinal content cecalward in much the same manner that ciliated epithelium of the trachea sweeps the contents upwards. In addition to this, one observes a broad peristaltic contraction of the muscularis propria."

If the walls are infiltrated by new growths, they obliterate all evidence of peristalsis as indicated by the rugae, over the involved area.

Dr. William W. Maver (Jersey City): I think a paper of this kind is of interest to all of us and emphasizes the fact that the intestinal tract is susceptible to carcinomatous growths. I believe we used to feel that the duodenum was one of the areas that was not very frequently involved by carcinoma. In our roentgenologic studies, we were inclined to pass over the intestines as not being of any particular importance unless there was something of a gross character present that was picked up readily. By the use of an altered technic, such as Dr. Baker has described (films being made at frequent intervals after the ingestion of the meal), it is possible that, in a great many instances, one may pick up these lesions in the early stages. Probably the most dependable symptom or sign we have from the x-ray is that of obstruction.

I recall 2 cases that I have had in the last year. One had, in the ascending portion of the duodenum, an annular growth that progressed very rapidly and gave symptoms referable to the stomach; at operation it was shown to be a carcinoma of the ascending portion of the duodenum of the annular type. The other case was one that showed in the x-ray only because of the fact that it obstructed, and it obstructed only because of the weight of the growth. It was a small nodular mass in the jejunum that, by its own weight, produced a moderate prolapse and caused the subsequent angulation that gave signs of dilatation and led to an operation. It was a nodular mass sufficient by its weight to angulate and obstruct, but not sufficient in size to invade enough of the lumen of the tube to obstruct it.

THE NEWER RADIOLOGIC METHODS OF GASTRO-INTESTINAL EXAMINATION

A Critical Evaluation and Practical Survey Based on Personal Experience

Raphael Pomeranz, M.D.,
Newark, N. J.

Gastro-intestinal examination by means of Roentgen-rays has become such a valuable addition to our clinical diagnostic armamentarium that a consideration of its importance and limitations is timely. This also permits us to exchange our personal experiences, a review, which in my opinion, is most important for the progress of this branch of science. Such an exchange of opinions, not only among the radiologists themselves, but also between the radiologist and the surgeon, the medical man and the general practitioner, should be encouraged, for it will benefit both the doctors and the patients.

Let us first consider what a routine gastro-intestinal examination by means of the x-rays consists of. It includes (1) a history, (2) a fluoroscopic examination and (3) radiography. The importance of a thorough *history* of the patient, covering not only the recent ailment but also his living habits, good or bad, cannot be sufficiently emphasized. *Fluoroscopic examination* and palpation under the screen, after administration of the opaque media, permits us to examine the living organ in a manner not otherwise possible. Palpation of the patient should precede the fluoroscopy. *Radiography* includes the taking of radiographs in different positions and at different intervals covering the motility of the G. I. tract from the time of intake of the opaque medium to the time of its elimination; it also includes a barium enema.

From this brief sketch you can readily see that an x-ray G. I. examination is not purely a laboratory procedure to be executed by a technician. It is, in reality, a clinical examination to be performed only by the trained physician familiar with the normal anatomic and physiologic appearance and function of these organs. It should give the examiner the opportunity of correlating indefinite clinical data with their definite anatomic and physiologic background. By this, I do not mean to underestimate the intuition of the pure clinician, not using the x-rays. The efficiency of this method of G. I. examination has been so much improved by many investigators since its introduction by Rieder at the beginning of the Roentgen era that its diagnostic accuracy, as confirmed by surgery or autopsy, has now reached the high percentage of 75-85%. In spite of this, errors in diagnosis are still made for many reasons. Some of the reasons for faulty diagnosis are: the complexity of the diagnostic problems in abdominal disease, the difficulties in technic, the inadequacy of the apparatus, the diversified training of the examiners, and failure to maintain the required standards of the examination. Consequently, several supplementary methods have been introduced and developed by men of experience; these, I wish to outline briefly.

Two schools of thought have left a strong imprint on the development of the G. I. examination: (1) The first, represented by Cole, demanded many radiographs of the organ,

often as many as several dozens; they completely neglected fluoroscopy. All the radiographs were then examined simultaneously in the view-box, giving the examiner as accurate a picture of the function of the organ as possible. Even moving pictures were attempted; however, these did not prove practical. These methods (moving pictures and multiple radiographs) are too costly for the average patient. (2) The other school, represented by Holzknecht, demanded a thorough fluoroscopy of the patient, with one or several radiographs of the area. This method, achieving remarkable results, was quickly recognized all over the world, and was fertile in the production of expert examiners. Holzknecht's associates brought further improvement, demanding aimed radiographs of a small area exactly under the screen, immediately after observation by the examiner. The necessary apparatus was constructed and, while relatively uncommon in this country, is now in general use abroad. The next step in diagnostic efficiency was the introduction, by Berg, of the technic of examining the gastro-intestinal mucous membrane with small amounts of opaque media. This method, in conjunction with the aimed radiographs under the screen, represents such a vast improvement of diagnostic efficiency as to amount to a revolution. It enables us to make early diagnosis by visualization of the minute anatomic changes; it gives great insight into the previously neglected problem of inflammatory changes in the gastro-intestinal mucous membrane (gastritis). This method requires great care in the preparation of both the opaque medium and the patient. A very fine suspension of barium (3 parts of barium dissolved in 4 parts of water) is administered. The patient, after taking and swallowing one mouthful, is fluoroscoped and palpated simultaneously in all possible positions; radiographs are then taken so as to cover the mucous membrane of the entire organ; in addition to this, aimed radiographs of the doubtful region may be taken. Some investigators place air into the stomach by insufflation through a small tube, a procedure which, in my opinion, is not practical. Sometimes, it may be necessary to perform a gastric lavage if too much secretion is found in the stomach. A recent modification of this method, designed particularly for the pyloric antrum and duodenum, was introduced by Nozdwig. He manipulates the patient in such a manner that the air bubble normally present in the stomach is displaced to the antrum and duodenum. By elevation of the lower half of the patient's abdomen and by turning him to the left side in supine position and with the help of manual palpation, the air bubble moves to the pyloric antrum displacing the barium. This method, I believe, is too laborious to be practical though it may be of value in selected cases.

Similar improvement in diagnostic efficiency was brought about by Knothe and Berg, in colonic examination. After thorough cleansing enemas, a fine, carefully prepared opaque fluid is introduced in small amounts, with or without air; the organ is thoroughly palpated under the screen while the fluid is flowing in; sectional aimed radiography follows. For practical purposes, it is often sufficient to insufflate the air in small quantities under the screen, after the elimination of the regular barium enema. It is understood that the examination of the gastro-intestinal mucous membrane, as outlined above, should precede or follow the routine examination with complete filling of the organs.

A new concept of functional pathology was introduced by Bergmann. He pointed out that, often the earliest sign of disease is the functional pathology without any anatomic basis, as for instance, in an irritation of the colon, mucous colitis. As a rule, no definite pathologic findings can be seen at necropsy. In conjunction with this viewpoint, I wish to emphasize the importance of raying the gall-bladder with every examination of stomach and duodenum—and, vice versa, with every stomach examination the gall-bladder should also be rayed. Knowing from experience how interrelated the functions of these organs are, we consider this rule justified. Another correction is the importance of recognizing the necessity of repeated re-examination of the same patient, at short intervals by the same examiner, if the original examination was negative, and if the clinical symptoms persist. We can readily see that an anatomic base for the clini-

cal symptoms may not be visualized until 4 to 6 weeks after the first examination. If a patient is examined by one man today and found negative, and if 6 weeks later another man reports positive findings, it is not fair to blame the first examiner for a faulty diagnosis. The same rule applies when the case is reversed; i. e., positive at the first examination and negative at the re-examination by another examiner. We know that certain ulcers of the stomach will disappear in 4 weeks so that no evidence can be found radiologically. On the other hand, a new one may develop in a different location. Repeated re-examination by the same examiner is particularly important in cases suspicious of early malignancy. I sincerely believe that by repeated serial re-examination many mistakes in diagnosis can be corrected, and the progress of treatment can be followed in such a way as to increase our knowledge. I feel certain that every radiologist would be willing to coöperate with his group of physicians in order to make the serial examination available to patients of moderate means.

After this general consideration of the subject, I wish to discuss some points in detail. It is evident that in this short summary I can stress only those points which I have found to be important in my experience.

Acute gastro-intestinal conditions: In all the acute abdominal conditions giving a clinical picture of a perforated ulcer or of a partial ileus, it is necessary to take flat films, without opaque media, in upright and lateral positions; looking for free air in the abdomen (under the diaphragm) or for horizontal levels. The latter may sometimes be better visualized in the A. P. view. Watch also the distribution of gas on the flat film as it may point to the place of the obstruction. In cases of partial ileus it is also important to secure a flat film of the G. U. tract in supine position. I had occasion, in 2 cases, to find marked intestinal and colonic gas distention due to a calculus in the left kidney pelvis associated with an infection. In 1 case it caused such a colonic distention as to obscure the entire clinical appearance of the patient. In the other, it caused pyloric spasms for a long period. The explanation is probably the functional disturbance of the autonomous system of the intestine as a result of toxemia from infection. In neither case was there any colicky pain. Considering the differential diagnosis of acute appendicitis, one cannot expect help from the x-rays, unless a stone is visualized in the right G. U. tract. Even then, final decision as to immediate operation rests with the physician or surgeon in charge; he must balance the clinical symptoms against the x-ray evidence. In cases of trauma to the abdomen causing a ruptured viscus, the same rule applies as to a case of perforated ulcer. The only proof of a traumatic gastro-intestinal condition is the operative finding. A post-traumatic ulcer is possible, though difficult to prove.

Pharynx and esophagus: Before undertaking any G. I. examination, one should always and thoroughly fluoroscope the chest. The examiner often finds a latent tuberculosis, an unsuspected compensated heart disease, or a specific aortitis which may throw light on the gastro-intestinal symptomatology. Also watch and examine the function of the left diaphragm for relaxation or for a high position (Dillon) which may explain many of the clinical symptoms.

Examining the pharynx, one should be familiar with the normal swallowing act in order to recognize any functional disturbance which may be present. Look for the residue of the opaque media left in the pyriform sinus or in the valleculae, as this may give a clue to the earliest sign of a central paralysis—as, for instance, a bulbar paralysis—a condition which I had the opportunity of recognizing on one occasion. *Esophagus*: One is not likely to miss organic defects of the esophagus. It is however, difficult to recognized varices in the form of small nodule-like elevations in the mucous membrane or in the form of small defects of the wall, semi-oval in shape. If a differential diagnosis of an intrinsic defect with an extra-esophageal mass is to be made, one should try to visualize the longitudinal folds of its mucous membrane; if they are preserved, the diagnosis of an extra-esophageal mass is probably correct. If doubtful, suggest an esophagascopy. This is also indicated in cases of cardiospasm at the lower end of the esophagus. Small ulcers which cannot be recognized under

the screen may be the cause. Aimed radiographs may help. The importance of examining the esophagus in all cardiac or mediastinal conditions is common knowledge. In cases of functional pathology, one should watch the amount of air swallowed with the opaque medium. When looking for a foreign body, give the patient a barium capsule before the examination, and note where it is retained; this procdeure is also indicated in severe spasm.

I wish to cite at this point, an interesting case of esophageal stricture. The patient was referred to me with the following history: A 17-year-old girl was supposed to have had diphtheria, one year prior to my examination. After 3 weeks at Soho Hospital, she was discharged as cured. After leaving the hospital, she began to refuse food, taking very little of anything but fluids. My examination revealed a sharply defined stricture at the level of the third thoracic vertebra. From that point, only a very thin line of fluid could be seen passing into the stomach. From the type of the stricture, I concluded, while examining the patient, that it could not be due to anything but a caustic substance—possibly lye. After I confronted the patient with this fact in no uncertain way, she broke down and admitted having taken lye 3 days before the doctor who had made the diagnosis of diphtheria had been called in.

We see in this case an instance of an x-ray examination's exposing the truth which had been successfully hidden by the patient for more than a year. This is an excellent illustration of the importance of an x-ray examination of the esophagus from the forensic standpoint. Another important condition to be kept in mind is congenital dilatation of the esophagus with or without cardiospasm. Of course, the diagnosis "congenital" should be made only after all other possibilities have been exhausted. These dilatations are not uncommon. A smooth pointed end of the cardia with preserved longitudinal mucous membrane folds (best illustrated by the aimed radiographs under the screen) together with the esophageal dilatation will substantiate the diagnosis. The esophageal atonia may be due to a central or peripheral lesion of the vagus nerve.

Stomach-cardia: Two conditions at this region are the most common causes of faulty diagnosis: early malignancy and par-esophageal hernia. If a *tumor* originates from the anterior wall growing towards the cardiac opening, the clinical symptoms will occur early in the course of the disease, and the radiologic determination should not be difficult. One will find a diminished air bubble, defective in outline even without the oqaque medium; or one can see the mass projecting into the air bubble. If, however, the tumor originates from the posterior wall of the stomach at a distance from the cardia, the clinical symptoms will be indefinite, and the radiologic determination may be very difficult, almost impossible, in the earliest stages. Never forget to examine in the supine left oblique position under the screen watching the intake of fluid; always complete the examination with several aimed radiographs in different angles. If still doubtful, insist on a re-examination in 3 or 4 weeks. The serial re-examination is, in my opinion, just as important and necessary as it is in doubtful incipient pulmonary tuberculosis.

Par-esophageal hernia is seldom thought of, though it is common when you look for it. In early malignancy we see a diminution of air in the upright position. In esophageal hernia, on the other hand, there is an increase of air in this region with distortion of the air bubble. In the left supine oblique position, under the screen, we see the hernial sac above the left diaphragm. The lower end of the esophagus may be widened and tortous. Small ulcers at the cardia will, as a rule, not be visualized, unless they are large enough to produce a niche, or a definite deformity of the mucous membrane (convergent folds). Another finding, usually normal, is the "cascade stomach"; if this is found, be sure that it is not caused by a small ulcer, or by some extragastric pressure.

Stomach—Pars media and pylorica: I wish to stress here the point that it is not an easy matter to become proficient in mucous membrane diagnosis. A solemn warning, both to the beginner and to the experienced man, is required; the examiner must check his conclusions again and again, before committing himself to a definite opinion. It is better to be conservative than over-anxious.

A niche is definite evidence of an ulcer. If it is a callous ulcer, the elevated wall will be noticeable under the screen by the quick but incomplete recession of the barium on compression. Convergent folds can sometimes be noted on the aimed radiographs. The ulcer-niche projects outside the stomach wall; it is

a "plus" in the shadow. The cancer niche, on the other hand, stays within the level of the gastric wall and shows complete recession of the opaque medium on compression under the screen. The cancer niche is also more flat and irregular. These are some points for differential diagnosis. The subsequent course of an ulcer-niche will show the effect of treatment; this fact can be used for distinguishing ulcer from malignancy. Recognition or elimination of the diagnosis of early gastric malignancy is the most important function of the radiologist; in this direction, aimed radioscopy and radiography are great steps forward. But still more important, in my experience, is serial examination at short intervals by the same examiner. One might find anatomic pitfalls in diagnosis, as in the case of a defect caused by a hypertrophic pylorus sphincter muscle. Kirklin recently reported the differential points in radiologic diagnosis with which no doubt you are familiar. Prepyloric or intrapyloric niches can be visualized more readily by using aimed radiography in upright position under the screen, than by the routine procedure.

Duodenum: Akerlund was the pioneer in the use of amied radiography in duodenal examination; he was able to visualize a niche in a very high percentage of his cases. With the help of relief study as above outlined, the efficiency of diagnosis has again been increased. The next step should be, in my opinion, a universal use of visualization of the gall-bladder together with the duodenum, using rapid exposures and low voltages, as suggested by Kirklin. The visualization should be attempted on the same film, so as to see the close relationship of these organs. Sometimes it may be necessary to visualize the hepatic flexure together with the gall-bladder and duodenum for better localization of the point of tenderness. This procedure, if followed by radioscopy, will be of great aid in clearing up doubtful cases.

Small intestine: Careful examination and diagnosis of lesions of the small intestine are often neglected. One should remember that the normal motility of a stomach filled with barium mixture is not 6 hours, but from 3 to 4 hours. For that reason, the patient should be re-examined after that time. If one suspects disease of the small intestine, administer to the patient the barium mixture every 15 minutes in small quantities, and examine both radioscopically and radiographically several times during the day at short intervals of about 1 to 1½ hours. Also look for air bubbles situated near the midline, as they are indicative of disease of the small intestine (ileum). This is particularly true in chronic intestinal tuberculosis.

Cecum: In cecal examination, I often found a combination of air and barium fluid insufflation of great diagnostic aid, preferably after evacuation of the barium enema. It is best accomplished by placing the patient in the left lateral horizontal position and lightly massaging the abdomen. By this manipulation, the air fills out the ascending colon and cecum. The patient should be rayed in this position.

Appendix: The x-ray diagnosis of pathologic appendix is made too often. A visualized appendix is a physiologic condition. For diagnostic purposes, as Czepa has recognized, the "not-visualized appendix" is of greater importance. An abnormally short appendix, with localized tenderness and limited mobility elicited on palpation under the screen on several occasions, are some of the symptoms warranting the suggestion of a diseased appendix. In women, the gynecologic findings should be established and correlated with the radiologic evidence. But even with all the positive radiologic findings present, one should be rather restrained in suggesting an operation on the basis of the roentgenologic report. Of course, there are cases where the x-ray evidence leaves no doubt, but as a rule, the clinician should have the last word in the question of the need for operative procedures.

Colon: I want to cite, at this point, a case of unusual intestinal neoplasm, corroborated at operation. A man, 45 years of age, noticed a mass, the size of an orange, in the right lower quadrant, 1 year after an appendectomy. The mass was freely movable and slightly tender on palpation. The general condition of the patient was good; he had a good appetite, had no pain, lost no weight and his bowels were not constipated. On examination by barium enema, supplemented by air insufflation and radiography, a defect could be no-

ticed at the region of the sigmoid: the sigmoid loop was displaced to the right side. From the relief study of the defective area, I was able to determine that the mucous membrane folds were still preserved. This indicated that the mass was growing around the sigmoid and was not due to a intra-sigmoid structure. At operation, a growth* originating from a nearby ileum loop and growing around the sigmoid was found. Most of the defect was due to spasm. The differential diganosis was possible only through the relief study of the mucous membrane of the defective area. A recent supplementary diagnostic method, the visualization of the liver and spleen by means of "Thorotrast" is not yet of practical value. It will probably be restricted to selected cases and will not be designed for general use in healthy human beings.

Summary

A routine G. I. examination should consist of: (1) A thorough history. (2) Palpation of the abdomen. (3) Radioscopic examination of the chest in all possible positions. This should include the examination of pharynx and esophagus while the patient takes the opaque medium. (4) Examination of the gastro-intestinal mucous membrane using small amounts of specially prepared opaque media (Berg), and aimed radiography under the screen with special attention to the point of tenderness. (5) Radiography and radioscopy upon complete filling of the organs which includes an enema with double contrast media. (6) Gall-bladder visualization with each G. I. examination. (Gall-bladder, duodenum and, if necessary, the hepatic flexure should preferably be visualized on one film.) (7) If there is any doubt as to the final diagnosis, *immediately* check your findings by re-examination.

Conclusions

(1) A routine G. I. examination is, in reality, a clinical procedure to be executed only by the trained physician. (2) Sectional aimed radiography in conjunction with thorough radioscopy and relief study of the gastro-intestinal mucous membrane is of great diagnostic value. (3) As a further aid in diagnosis, frequent serial re-examinations at short intervals by the same examiner are suggested for so-called negative or doubtful cases. (4) A close coöperation with the referring physician is of prime importance for better correlation of the clinical symptoms with the radiologic findings. A frequent exchange of opinions will be of benefit to the radiologist, to the clinician and to the patient.

*The section of this tumor was subsequently examined by Dr. Martland and Dr. Goldberg. They made a diagnosis of gelatinous carcinoma of the cecum, which grew around the terminal ileum and around the sigmoid.

Discussion

Dr. Charles F. Baker (Newark): I should like to compliment Dr. Pomeranz on his very comprehensive paper on this subject. It might be of interest to report a case coming under my observation a few months ago. On a certain Wednesay night, a patient suffered what appeared to be an intestinal obstruction. Repeated enemas and other treatment finally overcame it. The next day the patient was confined to bed, but on the second day he decided to return to work. On his way to the office he was seized with further pain, returned home, and passed through a similar train of symptoms. This was treated in the same manner as the previous attack. The next day he was referred for roentgen examination of the colon. Fortunately, a roentgenogram was made before the introduction of the barium enema, which disclosed the presence of a small calculus in the lower left ureter. The examination of the colon proved to be entirely negative. This experience should remind us that reflex spasm due to renal calculi, gallstones, a chronically inflamed appendix, or a gastric ulcer may sometimes cause serious intestinal symptoms which might lead to an erroneous diagnosis of intestinal obstruction.

Dr. S. A. Goldberg (Newark): Stenosis of the intestine, particularly following operation, is not rare. There are, however, only a few such cases in the literature. I had occasion to see some of the reported cases—particularly those in the ileum. The condition, of course, may be found in other parts of the bowel. Congenital stenosis is also common in many parts of the intestine. This fact must be recognized in order to avoid mistaking stenosis for carcinoma or tuberculosis—an error frequently made.

Dr. William A. Maver (Jersey City): I should like to ask a question about the post-traumatic ulcer, which Dr. Pomeranz reported. As I understood it, it was visualized 3 weeks after the trauma. I think we are entering dangerous ground when we enter this field; this particular ulcer seemed to have a good deal of scar tissue about the cap. I should like to know what proof the doctor had, that it *was* post-traumatic.

Dr. R. Pomeranz (Newark) (closing discussion): Dr. Klein asked me what happened in the case in which the resection was performed. I don't know what was done. The loop was probably connected with the cecum, or with the ascending colon. The patient died about 48 hours later, and no auotpsy was obtained.

Dr. Goldberg knows more about granulomas of the small intestines than I do. It was the first case

I had ever seen, and I did not have the opportunity of examining any of the sections of this tumor.

Dr. Maver asked about the post-traumatic ulcer. I am as doubtful about the x-ray diagnosis of a post-traumatic ulcer as he is. The only proof is the clinical evidence or the immediate operative finding. In the article just published in the A. M. A. Journal, the author came to the conclusion that the clinical history is of prime importance.

I appreciate Dr. Baker's report on the case of ureteral calculus. In our case, the probable explanation was that the infection caused toxemia followed by functional impairment of the intestines with the symptoms of flatulence and stasis. Perhaps the same explanation can be applied to his case.

CONSERVATIVE MANAGEMENT OF CHRONIC MIDDLE EAR SUPPURATION

Oram R. Kline, M.D.,
Camden, N. J.

Chronic suppurative otitis media is manifested by a continuous or intermittent discharge from the middle ear and results primarily from inadequate medical and surgical treatment of acute middle ear suppuration.

Not so many years ago, the average physician, treating an abscess of the middle ear, felt that he had fully discharged his duty if he faithfully attended his patient until the acute symptoms of pain, tenderness and fever had disappeared. In the absence of other symptoms, the discharge was not considered important; in fact, the patient was often advised that the ear should be permitted to run until it stopped of its own accord. This indifferent attitude toward the running ear has been combated with some measure of success, but unfortunately many physicians still do not appreciate the importance of following every patient with acute middle ear abscess until the ear is dry and remains dry. It should be considered as necessary to consult an otologist when an ear discharge has persisted for 6 weeks as when symptoms of acute surgical mastoiditis are present. If this course were followed, most of the chronic otorrheas, with their attendant complications and sequellae, would be prevented.

Although inadequate local treatment of the acute condition is of prime importance in causing transition into the chronic state, there are certain other conditions that contribute to delayed healing and that ultimately may prevent complete resolution of the acute inflammatory process. These additional etiologic factors may be classified as follows: (1) Severity of the original infection; possibly extensive bone necrosis has occurred, requiring surgical intervention. (2) Infections of the nasopharynx may be adding fuel to the flame by way of the Eustachian tube. (3) The patient's general resistance to infection may be lowered by faulty hygiene, improper diet, a chronic constitutional disease such as diabetes, syphilis and tuberculosis, or possibly by some distant focus of infection. (4) Local resistance to infection may be subnormal due to an arrested mastoid development.

Although the time allotted does not permit a detailed discussion of the etiology, I do wish to summarize the relation of arrested mastoid development to prolonged suppuration of the middle ear. This theory was first advanced by Wittmaack in 1918 and more recently emphasized and corroborated by Almour, Kopetzky and others. The tympanum, attic and antrum are, at first, filled with thick embryonic connective tissue covered by a delicate epithelium. As aeration occurs, there is an ingrowth of this thick connective tissue into the marrow spaces of the mastoid followed by a contraction or thinning out, permitting the epithelial covering to develop. The end result of normal development, requiring 3-5 years, is a complete replacement of all diploic bone by air containing spaces communicating with the antrum. Wittmaack and his corroborators assert that this normal pneumatization is arrested or stopped by an inflammatory condition occurring in the middle ear during this developmental period. If an otitis media occurs in the new-born or in infancy before the embryonic tissue has disappeared, the patient remains with a diploëtic or sclerotic mastoid and a middle ear and antrum lined with unresistant embryonic tissue instead of normal mucous membrane. If this logical theory is accepted, arrested mastoid development becomes a definite factor in the etiology of chronic suppurative otitis media.

In the acute stage of suppuration the entire

middle ear may be involved, viz., tympanic cavity, Eustachian tube, mastoid antrum and the neighboring mastoid cells. Complete healing of this inflammatory process may occur, resulting in a dry ear with very slight impairment of function. However, in the presence of one or more of the above-mentioned etiologic conditions, transition into the chronic state occurs after the infection has been localized and limited by the tendency of inflammatory tissue to undergo resolution and repair.

A diagnosis of the local disease process of this chronic infection is attempted by correlation and evaluation of data obtained from a careful history, symptoms, detailed otoscopic examination and x-ray. The bacteriologic findings in the purulent discharge usually present the picture of a mixed infection and, therefore, are of little significance in so far as the treatment is concerned unless vaccine therapy is to be used. Rarely, the bacilli and spirilla of Vincent predominate in the discharge; in such a case, arsphenamine locally and intravenously is of definite value in the treatment.

We should further include in our diagnosis the differentiation of those types requiring radical surgical procedures. Those patients presenting symptoms of labyrinthitis, perilabyrinthitis, meningitis, brain abscess, lateral sinus infection or facial nerve involvement, either twitching or paralysis, require operation as a life saving measure. If an acute exacerbation of a chronic mastoiditis develops, a radical operation is the safest procedure, but not always a necessary one. A positive fistula sign may call for operation, but if the infection can be controlled, fibrosis may occur and the sign disappear. A fistulous opening in the cortex or in the posterior bony canal wall usually requires operation, but we have had 2 in the latter location which became dry with conservative treatment. Petrous pyramid suppuration, if definitely diagnosed, should be drained. Large cholesteatomatous cavitation, not accessible through the tympanum, and massive mastoid necrosis must be dealt with surgically if a cure is to be effected. Finally, the present and future residence of the patient is a factor to be considered. If an otologist will not be available to take care of possible acute exacerbations and complications, a radical operation is indicated in many cases that otherwise would first be treated conservatively.

Although we have mentioned certain types of chronic suppurative otitis media which will often require radical mastoidectomy to effect a cure, we feel that conservative treatment should first be persistently attempted unless there is evidence of intracranial or labyrinthine involvement. This conclusion is founded upon the experience of having seen apparently intractable cases yield to treatment after operation had been advised and refused. The end result in 4 such cases was a marked improvement in the general health together with a dry ear or an inconstant scanty mucoid discharge.

The conservative treatment of this disease includes (1) the general management of the patient and (2) local treatment of the middle ear infection. The first is directed toward the removal or correction of existing etiologic and predisposing factors and the second consists of such minor surgical procedures as may be necessary to promote drainage; this should be followed by careful cleansing and by the application of an antiseptic by instillation, ionization or insufflation.

Time does not permit me to review the various methods of local therapy which have been successfully employed by different otologists; therefore, this paper will be limited to the routine followed in my practice for the last 3 years, during which time I have used iodine dusting powder as the local antiseptic.

Before presenting the detailed treatment, I wish to say something concerning the composition of this powder and the history of its use in chronic middle ear suppuration. It is not a chemical compound of iodine. It is iodine in a very finely divided condition distributed over boric acid as a carrier. The powder is prepared by adding an alcoholic solution of iodine to an alcoholic solution of boric acid. After this solution is freed of alcohol, a brownish powder is obtained. Powder with approximately 2% iodine content is the strength most frequently employed. This antiseptic was first made and used in 1915, but it was not until 1929 that its therapeutic value was reported to the profession. Beck, in July of that year, reported "unusually striking results" after 6

months' experience with this treatment which, he stated, had been suggested to him by Lederman. This was followed in October by Lederman's report covering 14 years' experience, in which he included 22 case histories. Following the publication of these papers, an increasing number of otologists began to use this antiseptic powder and many of us feel that it is a definite addition to our armamentarium for combating this stubborn disease.

Routine Office Management of Chronic Suppurative Otitis Media

History: The past and present medical history is obtained in an effort to uncover any general systemic condition that may be influencing the patient's resistance to infection. All details that can be recalled about the onset of the ear infection are noted. Careful questioning will often reveal that the patient dates his running ear from a recurrence or an exacerbation, rather than from the actual beginning of the infection. It is important to ascertain not only the duration, but also the character and amount, of the discharge. If there have been exacerbations, their frequency and severity should be known, together with the accompanying symptoms. It is also of interest to know the type of treatment that has been tried and its influence upon the progress of the disease.

Examination: The blood Wassermann is taken. A complete blood count often gives valuable information. The urine is examined particularly for sugar, albumin, casts and pus. If the history reveals any symptoms of tuberculosis, the patient is referred to an internist for detailed chest examination. The nose and throat are examined for evidence of sinusitis or other chronic infection. The mouth of the Eustachian tube is carefully inspected for adhesions, polypi, hypertrophied lips and neighboring hypertrophied or infected lymphoid tissue. Functional hearing tests are employed to determine the amount of hearing present. While cleansing the canal with cottton-wound applicators, the amount, consistency, and odor of the discharge are noted as well as any inflammation of the canal wall. The presence, size, and location of granulations are observed, and in addition, the appearance of the tympanic membrane if any is visible. Sometimes it is possible to locate bone necrosis by the use of a metal probe. The x-ray usually shows a sclerosed mastoid, giving us little or no information concerning the site of the infection. A culture and smear of the pus are sometimes of value.

General treatment: Before local treatment is instituted, the knowledge of the existence of certain constitutional diseases, such as diabetes, syphilis, tuberculosis, the anemias and chronic nephritis, is important. In the presence of systemic disease, appropriate general treatment must be carried out in conjunction with any local therapy that is employed.

It has been demonstrated also that the resistance of mucous membranes is definitely lowered by a deficiency in vitamins, nutritional imbalance of inorganic substances, allergia, and endocrine imbalance. The first 2 conditions may be adequately treated by proper diet and indicated medication; the correction of these may, in turn, markedly improve the symptoms of allergy and endocrine imbalance. Since vitamins A, B and D are of especial value in raising resistance to infection, it is often advisable to give some concentrated preparation of these vitamins in addition to the diet.

Normal resistance may be increased by instruction to the patient concerning exercise, fresh air, sunlight and clothing. Advice about nose blowing and bathing is of especial value. The nose should be cleansed by blowing with one or both nostrils open, but never by using sufficient force to produce sensations in the ears. Water entering the middle ear by way of the Eustachian tube or through a perforation in the membrana tympani is a frequent cause of continued suppuration and of recurrences. The head should never be under water and the affected ear should be tightly plugged with lamb's wool whenever there is a possibility of water entering the canal, as in washing the hair, taking a shower bath or swimming. In fact, it is much safer to avoid swimming under any conditions.

Associated diseases of the nose and throat must receive adequate treatment. This means the removal of adenoids and infected tonsils, the relief of sinus disease, either by conservative drainage or radical operation as may be indicated, the correction of septal deformities,

if they definitely obstruct either nasal breathing or drainage of infected sinuses, and the removal of hyperplastic posterior turbinal tips.

Local treatment: Occasionally, external canal infections are also present. If these are of bacterial origin, cotton cones dipped in cresatin or 2 to 10% phenol relieve the pain to some extent. It is my custom to rely upon hot compresses to localize these infections and, as a rule, to permit spontaneous drainage unless there is definite fluctuation. The skin of the canal is at all times kept covered with 2% yellow oxide of mercury ointment to guard against reinfection. I have had very little trouble with recurring furunculosis of the canal since using this plan as contrasted with my former practice of early incision. The presence of recurring furunculosis calls for autogenous vaccine therapy in addition to the local treatment. Otomycosis or fungoid inflammation of the canal usually responds promptly to the removal of all débris followed by the use of 2% salicylic acid in 50% alcohol.

After external canal inflammations have recieved attention, measures to promote drainage from the middle ear are attempted. If polypi are present, they are removed by the ear snare threaded with silk-worm gut. This method is much less painful and safer than using fine wire and is quite as efficient. Sharp punch forceps and delicate curettes are employed to eradicate other granulations, followed by the sparing application of 50% silver nitrate to those inaccessible to instruments. The utmost care is exercised to avoid any traction in the removal of granulations, since any pulling action may break down the only existing barrier between the area of infection and the meninges or labyrinth. The perforation, if too small to permit either adequate drainage or the indicated instrumentation, is enlarged.

The principle of local therapy, after drainage has been established, is to cleanse both the canal and middle ear cavity as thoroughly as possible in order that the iodine dusting powder may penetrate to the infected area.

After the larger granulations have been removed, the middle ear is carefully and painstakingly cleansed with small cotton-tipped applicators inserted through the perforation. Tenacious discharge and débris can sometimes be more easily dislodged and removed by alternately applying gentle suction and compressed air through a small metal tube curved at the tip. If a cholesteatoma is present, alcohol instillations followed by ether are of considerable aid in breaking it up so that it may more readily be removed. Catheterization of the Eustachian tube is of value in dislodging débris, especially that located in the region of the Eustachian orifice.

After thorough cleansing has been accomplished, the iodine dusting powder is insufflated through the perforation with a powder blower; additional powder may safely be permitted to remain in the canal, in contact with the perforation, inasmuch as no objectionable hardening or caking of this powder has been noted.

An accessory tube, straight or curved, is sometimes necessary in applying the powder to the site desired. If a metal tube is employed, it should be thoroughly cleansed and dried or corrosion will occur. Occasionally, patients complain of pain after introduction of the powder; if this is intense or prolonged, apply cocaine solution to the middle ear before each insufflation. This procedure, however, is rarely necessary. The iodine may give rise to a local dermatitis in the canal when the skin is unusually sensitive; but, this seldom occurs and can easily be controlled by protecting the canal with a bland ointment.

The home treatment is limited to cleansing the canal with cotton-wound applicators either dry or dipped in alcohol.

It has been my custom to give 2 treatments each week until the ear is dry and then request the patient to report at increasingly longer intervals in order that any tendency to recurrence may be controlled. Each patient is advised that he has a chronic infection that is possibly only temporarily arrested and that, therefore, he requires further observation. The importance of immediately reporting the return of any symptoms is emphasized and, in addition, the necessity of having the ear examined at 3 to 6-month intervals even in the absence of symptoms, is stressed.

DISCUSSION

Dr. James A. Fisher (Asbury Park): As Fenton has so aptly stated, the objects to be attained by treatment include securing and maintaining free drainage, determination of the type of infection,

aseptic cleansing, antiseptic treatment, removal of local or general causes of reinfection, drying up of discharge, and restoration of hearing.

The type of tympanic perforation existing in a given case affords an important index to the ease with which drainage may be effected and the results to be expected from one form of treatment or the other. Some perforations require enlargement, others when high, require an artificial opening low down for counter drainage.

Druss studied in serial sections 120 temporal bones in an effort to show exactly what rôle the epidermis plays in the repair and in the etiology of chronic suppuration of the middle ear.

Ingrowth of epithelium takes place especially in marginal perforations and in epitympanic perforations; the latter in about 90% of cases replaces the normal mucosal lining. This struggle between mucosa and epidermis is frequently the cause of suppurations which may continue for years. Thus, the discharge is not always due to bone disease or to an open Eustachian tube. The discharge or excretion of one type of epithelium acts as a foreign irritant to the other and prolongs the discharge.

GENITO-URINARY TUBERCULOSIS

Stanley R. Woodruff, M.D.,
Jersey City, N. J.

Tuberculosis of the genito-urinary tract has been more actively brought to the attention of practitioners of medicine in the last few years, and its early diagnosis made possible through the efforts of several investigators. The battle of the experts as to whether the tubercle bacillus could pass through a healthy kidney was satisfactorily settled by Medlar in 1926; and in 1929 Medlar proved conclusively that if the tubercle bacillus appears in the urine from a kidney, such a kidney is the seat of tuberculous disease. In 1932, Lieberthal and von Huth, after an exhaustive study, absolutely corroborated in every detail the conclusions of Medlar and his associates. Investigations by Lieberthal and von Huth are interesting. Having overloaded the circulation with tubercle bacilli of varied virulence and type, they stimulated diuresis with different agents. In spite of these drastic measures, the bacilli did not appear in the urine, which was carefully examined for 20 days. They also report that previous damage to the kidney by trauma or disease did not tend to make the organ permeable to the passage of the bacillus; this observation contradicts our previous concept of the influence of these agencies.

The coexistence of renal and genital tuberculosis is now being demonstrated more frequently—probably because the increased number of urologists in our communities is permitting a better and more scientific study of such patients. Since both renal and genital tuberculosis are secondary infections from a primary focus, there is nothing to prevent infection of both systems at the same time, and their close anatomical relationship makes interchange of infection very simple. This transmission, however, does not occur as frequently as one might suppose, for, clinically at least, the great majority of patients presenting themselves with urinary tuberculosis are free from the genital type. We have found, on the other hand, that when the latter is the presenting condition, the frequency of urinary involvement seems to be greater. It is quite possible, however, that with the recent advances in our knowledge, we shall find by closer study of these patients, a greater proportion of commingling of the infections. The early appearance of genital tuberculosis in the epididymis is likely to bring the patient's attention to this lesion sooner than an infection in the kidney, for in the latter case, early symptoms may be entirely wanting, and unfortunately, the urologist rarely sees a patient suffering with tuberculous infection of the kidney until marked changes have taken place in one or both organs. Renal and genital tuberculosis are always secondary infections, and usually follow actual lung infection or its accompanying lymphatic involvement; because of this relationship, a person suffering with the pulmonary type of infection is always in danger of distribution of the tubercle bacillus to the kidney, prostate, or epididymis. Remembering that the involvement of these organs is of hematogenous origin, we are faced with the fact that renal tuberculosis must, in the great majority of instances, be a bilateral infection. The truth of this can not be doubted by any one who reviews the painstaking studies of Medlar, Lieberthal and von Huth, Thomas, and Harris. That it has been denied in the past may be attributed to insufficient study of the patient and to the unrecognized fact that tuberculous infections of one kidney may heal and show absolutely no clinical results or func-

tional damage. With a tuberculous focus in some portion of the body accompanied by a dumping of the tubercle bacillus into the blood stream from time to time, there is no reason for doubting that continued or subsequent infection of the kidneys may take place. We have demonstrated in our own laboratory various healed infections, undoubtedly of different ages.

Most patients with renal tuberculosis presenting themselves to the urologist for examination are not cognizant of the fact that they have pulmonary tuberculosis; even if they are aware of this, they do not mention it, because, as a rule, the urinary symptoms predominate. Urinary tuberculosis is a peculiar disease; its symptoms may be remarkably active and distressing. Tuberculosis is classed as a chronic condition, but in the urinary tract it may show the most acute symptoms that one encounters. On the other hand, some patients complain of no urinary symptoms whatsoever, and yet show active tuberculous infection with caseation and marked renal destruction. The activity of symptoms in urinary tuberculosis depends largely upon the amount of infection of the bladder. This organ is never primarily infected by the tubercle bacillus, but always receives the infection from the kidneys above or from the genital tract below. Involvement of the ureter appears to be the chief agent in determining the amount of vesical infection. Remembering the hematogenous origin of renal infection, we expect to find the earliest and the greatest number of lesions in the cortex. This was true, according to Medlar, in 75% of the kidneys examined, and in this portion of kidney, healing takes place to a greater extent than in the medullary portion; in the latter, healing rarely occurs. The early cortical lesions are in the glomerulus, or within the capillary between the convoluted tubules. The medullary lesions have their origin in the lumen of the tubules, and are found with equal frequency in the lowest point of the loop of Henle and in the collecting tubules in the pyramids. This type is always secondary to an adjacent vascular lesion which has developed to a point where ulceration and destruction of tissue has taken place, with consequent discharge of the tubercle bacillus into the ruptured lumen of the tubule. Infections at this point are less likely to heal because of the infection of the tubule itself.

If renal tuberculosis is a bilateral disease, what factors govern the healing of these lesions? One can suggest only the time-honored "resistance of the patient". Medlar recognizes the hyperplastic type of infection accompanied by mononuclear tubercles in persons of high resistance. In these kidneys no caseation takes place, and healing occurs by scar formation with the destruction of the tubercle bacillus. In patients with poor resistance, polymorphonuclear leukocytes are attracted to the injured tissue, and an abscess results. If this abscess is near a tubule, it discharges into it, organisms appear in the urine, and cavitation ensues. If the minute abscess does not find its way into a tubule, the mononuclear leukocytes appear in large numbers; and if the reparative process proceeds satisfactorily, giant cells appear, the leukocytes and lymphocytes gradually disappear, and scar formation results. Calcification may also be the end result, as it often is in any tuberculous infection. Serial sections of a tuberculous kidney may show all types, stages and ages of infection. Cavitation in the kidney probably never heals, although the cavity may be surrounded by sufficient fibrous tissue to arrest it. If, however, a cavity is connected by a sinus to the renal pelvis or to several large collecting tubules and is therefore bathed in urine, its fate is sealed, and with it, that of the kidney. The presence of the tubercle bacillus in the urine does not always mean that a large caseating abscess is present, but, in fact, is more likely to indicate the contrary, for the bacillus appears more often from the smaller lesions than from those of greater extent. When tuberculous infections are in such direct contact with the tubules that an escape of the bacillus into their lumen takes place, the organism, of course, appears in the urine. As a result of the inflammatory thickening of the walls of the tubules, the latter become blocked and usually the lumen is destroyed. Therefore, no bacilli will be found in the urine if this point is the only area of infection. In kidneys almost or entirely destroyed by tuberculous infection, the bacillus is rarely found in the urine coming from this kidney; many pyonephrotic

organs, therefore, are removed without the actual diagnosis of tuberculosis having been made. The report of Hobbs that in 1000 autopsies on patients dying from pulmonary tuberculosis, only 16.2% showed clinical renal tuberculosis, means little in the light of our present knowledge. The importance of the tubercle bacillus in surgical lesions of the kidney will be realized when we consider that 30% of such conditions, according to Caulk, are tuberculous.

Tuberculosis of the kidney, as pathologic examinations of the removed specimens show, is usually far advanced before a nephrectomy is done. This was noted by Hunt, who reported that, of 189 kidneys removed for tuberculosis, only 9% could be classified as "early". There is little danger of the infection of one kidney by the other, except through a deposit of the tubercle bacilli into the blood stream. Lymphatic connection between the two is not constant, and since the lymphatics of the kidney are practically all of the efferent type, such a contingency may usually be dismissed. Obstructive pyelectasis of the opposite kidney, caused by constriction of the ureteral orifice due to tuberculous infection of the bladder, has been reported by Gibson, and must be considered. The difficulty of treating incipient renal tuberculosis by proper rest, diet, etc., is one of the great problems in urology today. Proper sanitorium treatment is denied the renal consumptive at this time, for all attention is given to patients showing lesions of hte lung. Many kidneys could be saved, and the lives of many patients suffering from bilateral renal tuberculosis could be spared, if long continued proper sanitorium supervision could be given.

The treatment of urinary tuberculosis must necessarily begin with a careful consideration of the organs involved. The keynote of all procedure must place decided emphasis on the fact that there should be no hurry about operative removal of a kidney. Each patient should be carefully checked by proper cystoscopic and urologic routine study before entering upon any treatment plan. One must decide whether the disease is in the early or late stage of infection; in border-line patients, it may be necessary to make several examinations before this can be determined. The amount of bladder involvement is often an important guide in reaching a conclusion.

In the early stages, when numerous small foci probably exist in both kidneys, absolute rest in bed, diet, and the usual hygienic treatment for tuberculosis should prevail. I wish again, to stress the fact that we are in great need of suitable sanatoria for the treatment of urinary tuberculosis. It is often impossible to obtain the entrance of a patient suffering in this manner, to the ordinary sanatorium because of the large number of lung cases there. The sufferers from renal tuberculosis are as much entitled to treatment as those with the pulmonary type; yet full recognition has not been given this phase of the disease. As the infection increases, we usually find that one kidney appears to bear the brunt of the attack, and by invasion of the medullary portion, definite caseation, cavitation and ulcerative conditions of the mucosa of the renal pelvis take place. If the other kidney has freed itself from infection, the patient may be considered from the surgical standpoint, for if cavitation has actually occurred, the kidney is probably doomed, and its early removal is certainly indicated. A diagnosis of cavitation can be made by ureteral catheterization, renal functional tests, and pyelographic delineation. It has been our custom for many years to avoid repeated cystoscopic examinations with catheterization of both ureters upon patients suffering from urinary tuberculosis. Notwithstanding the opinions of many excellent urologists to the contrary, we do not believe that, in the face of urinary infection—particularly when the bladder is involved—it is necessary or fitting to pass catheters up an apparently uninfected ureter. The only method that should be countenanced, we feel, is the introduction of the catheter through a terminal eye catheter already inserted into the mouth of the ureter. At the time of examination, if renal function is found equal and normal from both kidneys, double catheterization may be done; but if edema and other indications of tuberculous infection are found at one ureteral orifice and not at the other, we may nearly always conclude that the offending kidney is on the side of the edematous orifice. In such a case we concentrate our attention upon this kidney. We believe

that a sufficient demonstration of the condition of the opposite kidney may well be shown by the excretory type of pyelogram. At times, there are tuberculous infections of the kidney in which actual caseation and cavitation take place without showing a direct connection with the renal pelvis. This type will always show, by pyelogram, alterations in the renal pelvis, such as ulceration and a moth-eaten appearance in one or more calices. Such a kidney will show a marked diminution in functional output, and should be removed surgically unless the other kidney is incompetent. Actual breaking down of the renal pelvis, cavitation of the kidney substance, and terminal pyonephrosis need no consideration except nephrectomy. At times, one is confronted by the problem of undoubted bilateral tuberculous infection. If cavitation and pyonephrosis have practically destroyed one kidney, and the other still retains the outline of its renal pelvis not too greatly disturbed, it may be a good procedure to rid the patient of this enormous focus of mixed infection by nephrectomy. If, however, actual pyonephrosis exists in both kidneys, little can be accomplished by surgical means. The proper treatment of renal tuberculosis, therefore, implies the ability and necessity of making a painstaking diagnosis which may require several examinations when patients present themselves in the early stages of the disease. The admonition that one should never be in too much of a hurry, whatever the treatment imposed, is again repeated.

Genital tuberculosis offers an easier solution of the treatment problem than does tuberculosis of the urinary tract. If the disease is primarily in the prostate—and this, in our experience, is a particularly rare occurrence—surgical intervention is practically impossible, and the patient should be treated on the usual hygienic lines. As our knowledge of genital tuberculosis is limited largely to an acquaintance with involvement of the epididymis, the problem is usually surgical. While patients suffering with tuberculosis of the epididymis have, it is said, been helped by sunlight treatment, we have had no experience along this line, and our recommendation is usually a prompt removal of the entire epididymis and the vas as far up as the internal ring. If the testicle has not been infected, it may well be left in the scrotum; but if it shows evidence of invasion, the entire tract must be cleaned out.

One must always bear in mind that the surgical removal of any tuberculous area, whether in the urinary or in the genital tract, is only the beginning of the treatment. One of the secondary sites of involvement has been removed, but unless active and proper treatment for the initial tuberculous lesions is instituted, the patient will undoubtedly relapse, and, after a length of time, show the disease in some other organ. This is particularly true of the early types of the disease. In patients showing little involvement of the bladder and practically no demonstrable lesion of one kidney (if the other kidney is an old infected pyonephrotic one), operative removal is usually very successful; but in practically all patients with genito-urinary tuberculosis, sanitorium treatment, to follow the surgical procedure, is indicated.

DISCUSSION

Dr. Samuel E. Kramer (Perth Amboy): Dr. Woodruff's masterly presentation has emphasized that ulcero-caseous tuberculosis once established in any site in the genito-urinary system, if allowed to pursue its natural course, eventually results in widespread urinary, genital or urogenital involvement. Dr. Woodruff has admirably expressed the newer and more conservative concepts of the pathogenesis of renal involvement and the newer, more rational ideas as to the indications for therapeutic surgery. The recognition that tuberculosis of the kidney may heal spontaneously, rightly limits surgical intervention to those cases where ulcero-caseous lesions in the kidney parenchyma have broken down and communicated with the excretory passages. When this occurs, the close anatomic and functional relationship of all parts of the urinary and genital system makes the spread of tuberculous infection almost inevitable, and therein lies the rationale for surgical removal of a purely secondary focus of disease. We operate not to cure a tuberculous patient, but merely to attempt to prevent the spread of the disease within the urogenital tract. Dr. Woodruff emphasized this point when he stated that surgery for genito-urinary tuberculosis, is only the first step in the treatment.

The association of urinary and genital involvement has been the subject of urological discussion and dissension, but through careful statistical and clinical studies, our ideas on this relationship are becoming more clear. In this regard, I would emphasize the following points, most of which have been mentioned by Dr. Woodruff:

(1) So-called primary tuberculous involvement of the kidney, epididymis or prostate, occurs by hematogenous transfer from a distant latent glandular or pulmonary focus.

(2) Spread from one portion of the genito-urinary tract to another ocurs by direct extension along the excretory channels, lymphatic communications

and retrograde infection by reflux of bacillus-bearing secretions.

(3) The vast majority of urogenital tuberculous involvements are primarily renal.

(4) Pure genital tuberculosis comprises only a small proportion of the cases.

(5) Primary epididymal involvement is very much less frequent than primary kidney involvement.

(6) Where involvement of epididymis and kidney coexist, the latter is more frequently the original focus.

The frequent association between epididymal involvement and renal tuberculosis presupposes one of three possibilities: (1) Separate hematogenous infection of kidney and epididymis. (2) Lymphatic connection between these two widely separated foci. (3) Spread of infection from the kidney along the excretory channels of the urinary system with regional spread in the prostate and seminal vesicles and retrograde extension along the vas to the epididymis.

I have observed radio-graphic evidence to prove that the third possibility explains the association of these two lesions in many of the cases.

SURGERY OF THE KIDNEY AND URETER IN INFANTS AND CHILDREN*

MEREDITH F. CAMPBELL, M.D.,

Attending Urologist, Babies' and New York Nursery and Child's Hospitals; Assistant Visiting Urological Surgeon, Bellevue Hospital, New York

Montclair, N. J.

In the past, most operations on the upper urinary tract in juveniles have been for the removal of renal neoplasm. The comparatively recent advances in the field of pediatric urology have shown that infants and children are subject to practically every urologic disease known to exist in adults.' Moreover, the development of splendid miniature instruments has rendered complete urologic examination in the young both easy and accurate. We will briefly consider here the more common urosurgical conditions of the kidney and ureter in juveniles. The statistical data presented were devised by personal examination, and instrumental or operative treatment of 101 infants and children with surgical lesions of the supravesical tract. One hundred and fifty-two urosurgical procedures were carried out. Although this series of cases is perhaps numerically unimpressive, it bears the distinction of being the largest recorded personal series of cases of upper tract urosurgery in the young.

*(From the Departments of Children's Medicine, Surgery and Urology, Bellevue Hospital; the Babies' Hospital; the New York Nursery and Child's Hospital, New York; and the Department of Surgery, Mountainside Hospital, Montclair, N. J. Read before the Section on Pediatrics of the New Jersey State Medical Society, Atlantic City, N. J., June 9, 1933.)

SYMPTOMATOLOGY AND DIAGNOSIS

Intelligent surgical attack rests upon accurate diagnosis and, in the type of cases under discussion, can be made only by complete urologic examination. The symptoms of upper urinary tract disease and the indications for urologic examination in children are essentially the same and may be summarized as follows:

(1) *Pyuria*: A urologic examination is indicated when pyuria persists longer than 4 weeks despite intensive medical therapy. These patients include, therefore, the children with so-called chronic pyelitis or chronic cystitis. Yet, in some instances, persistent hyperacute renal infeciton or the development of perirenal abscess indicates examination and often surgical treatment. Urinary infection was a dominant symptom in 84% of our series.

(2) *Disturbances of urination*: These are chiefly persistent frequency, urgency, dysuria and incontinence. In 8 of our 101 cases, the initial diagnosis was enuresis, yet urologic examination revealed advanced upper tract damage requiring surgical treatment. In 3 of these, tuberculous kidneys were removed. Disturbances of urination were the indications for urolgoic examination in 32 patients (also 32%) in this series.

(3) *Hematuria*: This always calls for a complete urologic examination except when proved beyond doubt to be due to nephritis. Hematuria in children, although usually due to nephritis, is frequently an outstanding symptom of renal tuberculosis, tumor or urinary stone. In 7% of our cases the urologic examination was performed because of hematuria.

(4) *Tumor*: This is usually in the loin but may be suprapubic. We are here concerned only with renal enlargements or loin masses which may be due to hydronephrosis, neoplasm, pyonephrosis, or perinephritis with or without abscess. In one of our cases the tumor was a perirenal teratoma; in 13 patients

a neoplasm of the kidney existed and in 3 others, a perirenal abscess.

(5) *Pain*: Reno-ureteral pain always merits investigation. It is usually due to urinary backpressure which, in turn, is due to obstruction; it may, however, result from infection, stone or new growth. Pain in the loin was a prominent symptom in 22 cases.

Gastrointestinal disturbances manifested by anorexia, nausea, vomiting, diarrhea, constipation, indigestion, "biliousness", anemia, malnutrition, loss of strength, loss of weight or failure to gain are the outstanding general symptoms and occur in approximately half of all cases of chronic renal infection.

Fever is variable. In chronic renal infection it is commonly low grade and constant; in renal or adrenal tumor it is often irregular and sometimes is strikingly high. It was a dominant symptom in 13% of our cases. Fever of unexplained origin in a child is always an indication for a careful urinalysis.

Neurologic manifestations such as apathy, drowsiness, headache or irritability may be directly due to failing renal function and urinary toxemia. In general, children with chronic urinary infection show the picture of toxemic retardation.

The child suffering with one or more of the foregoing urinary tract symptom complexes is entitled to a urologic survey. Yet, before this is carried out, certain pre-cystoscopic data should be acquired. These data include a careful urinalysis, particularly for pus, blood and bacteria,* a plain x-ray of the urinary tract for stone, spinal defects or unusual shadows, estimation of the vesical residuum, cystography, intravenous pyelography and a determination of the renal function by phenolsulphonphthalein output and blood chemistry (non-protein-nitrogen or blood urea). The foregoing data, especially the intravenous urograms, may suggest the diagnosis. I have found excretion urography of reliable diagnostic value in approximately half of the children in whom it was used.

Having acquired this information, we perform cystoscopy, ureter catheterization and divided renal function tests exactly as in adults. Ureteral stricture or other obstruction is frequently the cause of difficulty during catheterization. The posterior urethra should always be carefully examined; in 4 instances I found there, an ectopic ureteral orifice. Retrograde pyelography is required when precystoscopic intravenous urography has been inadequate or omitted. I do not hesitate to make bilateral retrograde pyelograms when they are required, although excretion urography has greatly reduced the necessity for this procedure. However, I have seldom removed a kidney on the data obtained by excretion urography alone.

As a rule, an accurate urologic diagnosis is easily made by employing the foregoing methods. The lesions found in the various age groups are shown in Table I. The severity of these lesions is emphasized by the radical surgical treatment which many of them demanded (Table II).

Treatment

The surgical treatment depends upon the etiology. In many instances of mild infected hydronephrosis secondary to congenital ureteral stricture, gradual periodic ureteral dilatation by the passage of catheters reëstablishes free drainage; not a few of these will be cured. In the young, this dilatation is achieved by the passage of 2, 3 and 4 small ureteral (4 F.) catheters side by side. Technical difficulties engendered by the small calibre of the urethra (and therefore by the small gauge of the cystoscope) demand this multiple catheter method rather than the passage of a single large dilating bougie such as the one we commonly employ for ureteral dilatation in adults. Sometimes, stones retained by ureteral atresia will pass spontaneously following ureteral dilatation as just described. In a girl of 19 months, 2 uric acid stones were passed from the lower left ureter following ureteral dilatation with 3 4 F. catheters. In 3 other cases, ureteroceles whose pin-point orifices obstructed ureteral

*In the female, only catheterized specimens are worth careful examination. This is particularly true when bacteriologic studies are to be made. Catheterization also rules out pyuria of vaginal origin. In the male, a satisfactory specimen may usually be obtained by voiding if the meatus and glans are first freely exposed and cleansed and a few c.c. of urine are passed before specimen collection is begun. When this is impracticable, catheterization must be carried out.

TABLE I

OPERATIONS UPON THE KIDNEY AND URETER IN JUVENILES—AGE GROUPS

(101 cases)

	0-3 mos.	3-6 mos.	7-12 mos.	1-3 yr.	4-6 yr.	7-10 yr.	11-15 yr.	Total
Nephrectomy	2	2	8	12	10	13	4	51
Ureteronephrectomy			1	2	1	2	1	8
Ureteroheminephrectomy		1		1	1	1		4
Nephrostomy			2		2	2	2	8
Decapsulation								
Unilateral					2			2
Bilateral			1					1
Nephropexy					1			1
Renal exploratory				2	2		1	5
Pyelotomy						1		1
Pyeloureteroplasty					1	1	1	3
Resection aberrant vessels				1		2	1	4
Ureterostomy								
Unilateral			1					1
Bilateral			3					3
Resection of ureters (bilateral)			1					1
Ureteral Meatotomy (bilateral transvesical)			1	2			1	4
Ureteral dilatation								
For stricture	3	1	6	10	7	6	2	35
For stone				1	2			3
Fulguration ureterocele				2	1			3
Perinephric abscess (incision and drainage)	2				1			3
Ureter transplantation								
To bowel				1	1			2
To bladder					1			1

outflow were fulgurated transversely. Other procedures carried out in this series were more distinctly surgical; their variety as well as the condition for which they were employed are shown in Table II.

RESULTS

The operative results and the mortality in this series are shown in Table III. Except for acidosis which is likely to develop following any severe surgical procedure in a young child, our greatest operative hazard was surgical shock; this may be due to hemorrhage or to the removal of a large mass. The latter may be disastrous because of the trauma coincident to the removal of a large kidney tumor, for example, or it may follow the sudden evacuation of a large mass to whose physical effects the body has become accustomed. The latter is well illustrated in 2 cases: one 7 months of age, one 10 years old. The first had a perirenal hydronephrosis; the second had an intrarenal hydronephrosis. The simple evacuation of the sac (which held about a liter of fluid in each instance) was followed promptly by death in the first instance and by profound shock in the second. In very young children hemorrhage is of greater concern than infection and in all children, it is best combated by unusually liberal blood transfusions and by the administration of large quantities of fluid (glucose-saline). In seriously ill patients who require a large amount of fluid and are unable to take it by mouth, Brush's apparatus has been, in my experience, most helpful for the continuous intravenous infusion of glucose-saline. We have thus continuously given fluid for as long as 4 days. Although liberal fluid administration and blood transfusions are of paramount importance in children undergoing major urologic operations, these young patients withstand these major urologic attacks much better than their elders. Given my choice, as far as morbidity and mortality are concerned, I would rather operate upon the young child. For example, ureteroheminephrectomy was performed in a girl 6 months old; her postoperative course was unusually tranquil. Yet the operative shock of removing half of the kidney is much greater than that of total nephrectomy.

SUMMARY

Attention is directed to the character and treatment of the more common surgical lesions of the kidney and ureter in juveniles. Adequate treatment depends upon accurate diagnosis. This requires a careful and complete

Operative procedures employed in surgical lesions of the kidney and ureter in infants and children (101 cases)

*	NEPHRECTOMY	URETRONEPHRECTOMY	URETEROHEMINEPHRECTOMY	NEPHROSTOMY	DECAPSULATION UNILATERAL	DECAPSULATION BILATERAL	NEPHROPEXY	PYELOTOMY	PYELOURETEROPLASTY	RENAL EXPLORATORY	RESECTION ABERRANT VESSELS	URETEROSTOMY UNILATERAL	URETEROSTOMY BILATERAL	BILATERAL URETER RESECTION	TRANSVES. BILAT. URETERAL MEATOTOMY	FULGURATION URETEROCELE	URETERAL DILATATION STONE	URETERAL DILATATION STRICTURE	INCISION AND DRAIN. PERIRENAL ABSCESS	URETERAL TRANSPLANTATION TO BLADDER	URETERAL TRANSPLANTATION TO BOWEL
HYDRONEPHROSIS (infected, etiology undetermined)	2																				
PYELONEPHRITIS (suppurative)	5					1															
PYONEPHROSIS	5		2																		
RENAL TUBERCULOSIS	5																				
RENAL TUMOR	14									4											
RENAL STONE	4							1													
PERIRENAL ABSCESS	1																		3		
RENAL AGENESIS										1											
ABERRANT VESSELS KIDNEY	4										3										
ABERRANT VESSELS LOWER URETER	1										1										
URETER STRICTURE URETERO-PELVIC JUNCTION	8		1	5	1		1		3									1			
URETERO-VESICAL JUNCTION		5	1	3	1							1	3	1	4		1	35			
OTHER SITE	1																	2			
URETEROCELE		3														2	1	5			
URETER STONE	1															1	1				
BLADDER EXTROPHY																					2
BLADDER DIVERTICULUM																				1	
	51	8	4	8	2	1	1	1	3	5	4	1	3	1	4	3	3	43	3	1	2

*Hydronephrosis existed with all of the obstructive lesions

Table II

TABLE III

RESULTS OF OPERATIONS UPON THE KIDNEY AND URETER IN JUVENILES

(101 cases)

	Ages							
	0-3 mos.	3-6 mos.	7-12 mos.	1-3 yr.	4-6 yr.	7-10 yr.	11-15 yr.	Total
Cured	1	1	3	8	7	12	1	33
Improved	2	1	8	12	11	8	6	48
Unimproved			1		2			3
Died								17
Causes of death:								
Surgical shock					8*			
Urologic disease					3			
Non-urologic disease					6			

*5 following nephrectomy for large tumors.

urologic examination which is easily performed and which is similar in all details to that employed in adults. If fluids are copiously administered and blood transfusion is liberally employed, infants and children withstand radical urosurgical operations more satisfactorily than their elders. On the other hand, acidosis and shock must be strenuously combated. The accompanying tables adequately indicate that children are subject to every lesion of the upper urinary tract known to exist in adults. It is only fair to give to the child with urologic symptoms the same opportunities for accurate diagnosis, rational treatment and the chance to live which we customarily extend to the adult.

DISCUSSION

Dr. A. Haines Lippincott (Camden): The urologic conditions of children present practically the same problems that we have in the adult. It is, I think, due to Dr. Campbell, as much as to anyone in this country, that we have learned that these disorders can be diagnosed and treated during infancy and childhood just as now that the corresponding conditions can be taken care of in the adult. My experience in urologic surgery on infants has been very limited, but I have carefully followed Dr. Campbell's work and I have seen him operate. I am proud of the fact that urologic procedures can be applied to the patient at any time from birth to old age.

Dr. F. W. Lathrop (Plainfield): I should like to ask what effect transplantation of the ureter into the colon had on bowel retention and on control of urinary output.

Dr. Campbell: In extrophy, ureteral transplantation should be delayed until the third or fourth year when the child will have satisfactory rectal control. The great problem following ureterosigmoidostomy is the postoperative dilatation of the upper urinary tract which regularly occurs, yet in some cases apparently disappears later. Doubtless the Mayos have operated upon more of these cases than any other surgeons and, as recently reported by Braasch and Walters, their check-up by intravenous urography shows a marked dilatation immediately postoperative; yet as time goes on, it often regresses. Some of the late postoperative excretion urograms are surprisingly normal. Any surgeon transplanting ureters to the bowel should expect ureteral dilatation afterwards. As to urinary control, children over 3 or 4 years do as well as adults. They go 3 or 4 hours between evacuations.

LEAD ABSORPTION AND LEAD POISONING

A Clinical and Pathologic Analysis of 100 Cases

OTTO LOWY, M.D.,
and
LOUIS J. LEVINSON, M.D.,
Newark, N. J.

The incorporation of lead poisoning as a compensable disease under the amendment to the New Jersey Workmen's Compensation Act of 1924, has within recent years focused a great deal of attention on the differentiation between lead poisoning and lead absorption. Within the past few years insurance companies have suffered severe losses as a result of awards in cases of lead poisoning. We realize that, in general, the lead industry is a hazardous one and that men exposed to lead in its various forms suffer from many objective and subjective symptoms which deserve compensation. However, in our examinations, we have seen so many claims precipitated by loss of employment, that we have set up rigid criteria for a diagnosis of lead poisoning. Since most of the cases referred to us give a history of lead exposure, the problem usually resolves itself into a differentiation between lead absorption and lead poisoning. We, therefore,

place slight stress on subjective symptoms and emphasize our objective findings. The objective signs are found in the physcial examination and the laboratory data.

In lead absorption, the physical findings are usually negative, although sometimes we find a lead line. Our laboratory examinations consist of a complete routine urinalysis, a qualitative examination of the urine for lead (the Lederer test) and a complete hematological study, which at times included the Van den Berg and fragility tests. We are especially interested in the presence of lead in the urine in order to determine actual lead absorption and elimination, for a blood picture associated with lead intoxication or absorption may simulate other conditions.

In lead absorption we rarely find evidence of renal impairment; albumin and casts are not found in the urine. The presence of lead in the urine and stool indicates the process of lead elimination, the result of previous absorption. In the hematological study, great care is necessary. The mere presence of punctate basophilia is not enough to justify a diagnosis of lead poisoning.

Aub and his associates have shown the definite relationship existing between lead absorption and lead intoxication. Though lead absorption, in itself, apparently produces no symptoms in the subject, it should always be considered a state potentially preliminary to lead poisoning. For this reason frequent physical and laboratory examinations of individuals exposed to lead are necessary. Of these precautions the study of the blood is perhaps the most valuable. A sudden reduction in hemoglobin associated with a proportionate fall in the red cell count should always be considered a danger signal. In an analysis of 100 cases of lead poisoning, we have observed that of those individuals who are sufficiently sensitive to develop lead intoxication, 44.2% do so during the first year of exposure and 15.4% during their second year. A study of new employees during the first year, to determine their sensitivity, might therefore be of prophylactic importance.

Cases of lead intoxication may be divided into 2 groups:

Group I. Acute lead poisoning, represented by acute lead encephalopathy.

Group II. Chronic lead poisoning with acute toxic episodes.

In this paper we limit ourselves to chronic lead poisoning with acute toxic episodes. This group may be further subdivided into 4 types:

Group 1, Lead intoxication with evidence of hemopoiesis in the peripheral circulation and no permanent damage (3 cases).

Group 2, Lead intoxication with evidence of hemopoiesis plus central nervous system involvement (43 cases).

Group 3, Lead intoxication with evidence of renal involvement (16 cases).

Group 4, Lead intoxication in which hemopoiesis has disappeared and residual findings are the main consideration (38 cases).

First Group

The first group comprised only 3% of the total of 100 cases. There are probably many more cases of this type, but they do not reach us until they have developed other findings.

Case No. 20. A white male, aged 32, complaining of poor appetite, dizziness and pain in the extremities had been exposed for 9 months. He had marked pallor of the skin and a lead line. There was lead in the urine. His blood showed a 60% hemoglobin (Sahli), 4,000,000 red blood cells, 22 stippled cells per 100 white blood cells and the presence of macrocytes. There were no other objective findings.

Case No. 59. A colored male, aged 36, complaining of loss of appetite and abdominal pain, had been exposed for a period of 2 months. Physical examination revealed a lead line. His blood showed a 68% hemoglobin (Sahli), 4,100,000 red blood cells, 38 stippled cells per 100 white blood cells; macrocytes were present. There was lead in the urine, but there were no other objective findings.

Case No. 60. A colored male, aged 23, complained of headache, constipation, joint pains and a poor appetite. Examination of the blood showed a 70% hemoglobin (Sahli), 3,800,000 red blood cells, 32 stippled cells per 100 white blood cells and the presence of macrocytes. Lead was found in the urine.

After therapy these patients showed no evidence of permanent damage.

In this group we base our diagnosis of lead intoxication on the hematologic findings. In all of these cases there is a mild secondary anemia associated with stippling and macrocytes. The presence of macrocytes is an important indication of hyperactivity of the hemopoietic centers. It is only when normal

replacement fails to keep pace with the inhibition resulting from lead intoxication that macrocytes appear.

Stippling has been found associated with many other conditions. In a series of experiments which we performed with aniline products, we obtained blood pictures that simulated lead poisoning. We have concluded that stippling in itself is an index of bone marrow irritation, and that the presence of macrocytes is significant of hasty erythropoiesis.

As a general protoplasmic poison, lead has its greatest effect on young and less highly differentiated tissues. The intravenous use of colloidal lead for the treatment of malignancies is based on this. It is, therefore, not surprising that the hemopoietic system, which is composed chiefly of immature cells, should be one of the first to be affected.

Second Group

In the second group, the central nervous system is involved. This represents our most important and commonest syndrome. The most frequent finding in these cases is tremors; these are usually fine and resemble those of Basedow's disease. However, in an acute fulminating toxic episode, coarse tremors of both extremities are not uncommon. In our series, tremors occurred in the following frequency:

98% showed tremors of the fingers.
80% showed tremors of the eyelids.
29% showed tremors of the tongue.
18% showed perioral tremors.

These tremors also appeared in various combinations.

Peripheral neuritis was present in 2 out of the entire group of 43 cases, an incidence of 4.4%. In one case there was a wrist drop and in another a weakness of the middle and ring fingers of both hands.

At the onset of the disease, it is impossible to predict which cases will show permanent damage and which will clear up completely with treatment. The outcome depends on the existing pathology, and this in turn on the susceptibility of the patient.

Recent experimental work has shown that lead has a specific effect on the nervous system. In the peripheral nerves it provokes, according to Freeman, a somewhat discontinuous degeneration of a severe character, accompanied by marked proliferation of the Schwann cells. In the central nervous system, lead provokes simple or hydropic degeneration of the ganglion cells, particularly the larger ones in the basal ganglia, brain stem, and the spinal cord—a degeneration that may go on to the complete hyalinization and death of cells. There is a proliferation of the vascular adventitia, often accompanied by intimal hyperplasia and new vessel formation. This is the picture of the toxic reaction to the circulating lead. The prognosis depends on the pathology present at the time treatment is instituted. Chromatolysis and hydropic degeneration are reversible processes. Once complete degeneration and hyalinization have taken place, the damage is irreparable and cannot be completely remedied even by the most vigorous treatment.

The consensus of opinion is that renal involvement is associated with lead intoxication. There is a question, however, as to the amount of damage caused by an active lead stream. Aub states that the urinary findings, blood chemistry and blood pressure hardly point to a marked renal involvement.

Third Group

The third group represents a series of cases showing evidence of renal damage. In the entire group of 100 cases, 28% had albumin and 23% had casts in the urine. An interesting and repeated observation has been that in acute toxic episodes we often find moderate amounts of albumin in the urine associated with casts. However, during treatment, the casts and albumin promptly disappear. We consider this reaction a toxic nephrosis due to irritation of the kidney by the circulating lead.

The blood pressure, as a rule, is not elevated; only in 7 cases did we find hypertension. In these, the systolic blood pressure ranged from 150 to 200, and the diastolic from 75 to 120. In the group with renal involvement, showing no hypertension, the average duration of exposure was 37 months. In those with hypertension, the average duration was 64 months. Though it is difficult to reach any definite conclusion from so limited a number of cases, the clinical and laboratory data seem

to indicate an aggravated renal condition with added exposure.

In a series of animal experiments performed by Dr. Slavko Pejic, it was found that: (1) the earliest lesions in the guinea pig kidney due to lead carbonate poisoning are moderate parenchymatous degeneration and fatty infiltration of the renal epithelium, without microscopic lesions of the blood vessels; (2) after 6 months' exposure to the drug, a slight proliferation of the interstitial connective tissue was noted; (3) at the end of the seventh month there resulted secondary contracted kidneys.

These experiments describe changes which probably parallel those in the kidneys of workers suffering from lead intoxication as evidenced by laboratory and purely clinical examinations. Unfortunately, postmortem examinations on these patients are too few to be of any assistance.

Fourth Group

The fourth group contains a series of cases which are difficult to evaluate. In this group there are 38 subjects who at one time showed definite signs of lead intoxication. At the beginning of this study, they showed no evidence of acute involvement of the hemopoietic system. In some instances, however, there was definite evidence of lead absorption and elimination. In this group, the outstanding feature was an involvement of the nervous system which resisted therapeutic measures. As a rule, the involvement was mild and there was only one patient in the series who could be considered totally disabled.

The pathology described above accounts for the residuals in those patients with central nervous system involvement. Tremors may be the only objective sign. However, in rare instances, involvement may be so severe as to present a Parkinsonian syndrome. This is illustrated in the following case:

H. S., white male, 45 years old, had worked for a battery corporation from June 1930 to February 12, 1932. He first noticed symptoms in September, 1930. He received compensation for lead poisoning. *Complaints* at the time of examination (March 29, 1932) were: occasional nausea, weakness of arms and legs, pain in the extremities, dimness of vision, and occasional frontal headaches.

Physical examination: Weight 160 pounds. Height 5 ft. 5¾ in. Blood pressure 130/80. Dynamometer reading: right hand 40 kilograms, left hand 5 kilograms. All the reflexes were increased. He had a marked ankle clonus, a positive Babinski sign on the left side, and nystagmus to the left. Pupils were dilated but reacted to light. Facial expression was mask-like. There were marked tremors of tongue, hands, fingers and eyelids. Finger to nose test showed marked intention tremor and overshooting. Gait was shuffling. Associated movements, such as swinging of arms, were absent. Eye grounds were negative.

Laboratory examination: The blood picture, although it did not indicate lead poisoning, did show a definite lead absorption. A moderate amount of lead was found in the urine.

At that time we concluded that, in view of the history and laboratory findings, this man had an involvement of the basal ganglia due to lead intoxication. We could not state whether treatment would cause an improvement in his condition. Today, after therapy, there is no evidence of improvement.

Conclusions

(1) One hundred cases of lead poisoning were analyzed.

(2) A definite method of differentiation between lead absorption and lead poisoning was outlined.

(3) There is an involvement of the central nervous system in lead poisoning which does not, in all cases, yield to therapy.

Discussion

Dr. Max Kummel: The differentiation between lead absorption and lead poisoning is of utmost importance from the legal and medical viewpoints. Legally, lead poisoning is a compensable occupational disease, while lead absorption is a condition of no legal standing. Medically, lead absorption calls for restriction of exposure and increase of *elimination*, while lead poisoning indicates complete cessation of exposure and immediate fixation of the circulating lead. Recent observations have shown that every worker in the lead industries absorbs lead but not every one of them suffers from lead poisoning. To determine where the one condition ends and the other begins, it is necessary to take into consideration the various etiologic factors in the development of lead poisoning.

As stated above, every lead worker absorbs lead into his system; whether or not this absorption will prove harmful depends entirely upon the relation between the absorption and elimination. As long as elimination keeps pace with, or is ahead of, the absorption, no poisoning occurs. Furthermore, even when lead absorption trails behind elimination, toxic symptoms do not appear until the point of tolerance is reached. It is at this point, when the subjective symptoms such as colic, headache and vomiting appear, that we finally reach the stage of lead intoxication or poisoning.

During the stage of absorption the clinical picture is confined to an occasional objective sign, such as the lead line on the gums, the saturnine color of the skin, the blood changes or the finding of lead in the excretions. This is generally discovered on routine examination, since the patient is not disabled and has no complaints. The relative length of the period of absorption depends on the extent of the protective devices, the number of hours per

day and days per week, the general hygiene and, above all, the susceptibility of the individual worker. Long hours daily, 7 days per week, are certain to shorten the period of absorption and hasten the intoxication.

Owing to the peculiar behavior of lead in the human body, absorption may take place long after exposure has ceased. This is due to the deposits of lead in the long bones and to their mobilization by a change in the metabolism on the acid side. This may be brought about by any condition changing the pH of the blood, such as starvation, acid diet, shock, or an attack of grippe. Furthermore, even an acute exacerbation of lead poisoning may be brought about during the course of treatment by injudicious elimination. It is still an open question whether treatment by elimination is a justifiable procedure.

Dr. Lowy classifies chronic lead poisoning with acute toxic episodes into 4 groups. It appears to me that these groups represent the different stages of the disease. The first group of 3 (3%) merely represents the early stages before residual pathology has developed. His second group is characterized by central nervous system manifestations of which tremors constitute the outstanding feature. These may or may not disappear, the outcome depending upon residual pathology. I feel that the residual pathology is not the only factor; personal idiosyncracy and method of treatment are just as important. I recollect 2 men with an apparently mild plumbism who developed most marked encephalopathies after a course of treatment. In my experience, the coarse tremors appeared in the later stages of encephalopathy and have resisted all forms of treatment.

The doctor's third group of 23-28% shows evidence of renal involvement. A similar series of my own showed 18%. The difficulty is that we do not know the condition of the kidneys prior to the exposure. The effect of lead on the kidney is a disputed question. However, in several of our cases a pre-employment urine analysis disclosed negative findings.

The last group mentioned by Dr. Lowy is one in which all of the acute symptoms have subsided (the blood showing or not showing some anemia) but in which the residual pathology has progressed sufficiently to indicate organic changes on physical examination. In this group we find patients with intention tremors, disturbance of gait, paralysis, convulsive seizures, and psychosis.

Dr. Lowy does not consider a quantitative analysis of the lead in the urine advisable, because this does not prove anything beyond the fact that there is lead elimination. It has been claimed that lead is a constituent of normal urine; but it is not present in the body in sufficient amount to account for it. Bloomfield's and Isbell's investigation disclosed the fact that minimal amounts of lead are normally present in the atmosphere of city streets, automobile repair shops and industrial establishments not using lead. This may, in a measure, account for the presence of minute quantities of lead in the excretions of persons with no history of industrial lead exposure. Dr. R. A. Kehoe and associates have shown that similar amounts of lead were found in the excretions of persons who had subsisted on a special diet. Hence a quantitative analysis would indicate not only the presence of lead but, if found in amounts exceeding the so-called minimal, would clearly indicate a pathological condition.

It is true that the lead industry has been taxed heavily for its incidence of poisoning. It has been punished severely for its lethargy but out of this punishment came awakening and the realization that the way to relieve the employer and his carrier of their heavy burden is prevention. The Eagle Picher Lead Company of Newark, New Jersey, has approached the solution of the problem by the coordination of the medical, legal and engineering departments with the coöperation of the executives and employers. A pre-employment examination avoids the so-called "aggravation" cases by excluding the anemic and cardio-nephritics while periodic examinations disclose the potential and help arrest the incipient. Exhaust ventilation, respirators, gloves, showers and change of clothing limit the amount of absorption, while proper diet and hygiene together with sensible working hours and adequate rest periods increase the resistance and elimination.

In concluding, I wish to state that I deem it a great honor and privilege to have had the opportunity of opening the discussion of so important a subject. I wish to commend Dr. Lowy for the splendid paper he presented here this morning. I am fully cognizant of the effort and labor involved in the investigation, examinations, tabulation and repeated check-ups of 100 cases of lead poisoning. I am sure it will prove of great value to lead industries in particular, and industrial physicians in general.

Dr. Hyman I. Goldstein (Camden): Because of its practical importance, I wish to emphasize the danger to children of toys, furniture, and many small playthings colored with lead paint. Babies and young children have been known to suffer from anemia and gastro-intestinal disturbances due to biting and chewing these lead-painted toys. X-ray studies of long bones have disclosed lead deposits in these suffering children. Calcium levulinate, calcium gluconate *intravenously* and the use of perparin hydrochloride, magnesium sulphate, etc., have promptly relieved patients suffering from attacks of lead colic. What is Dr. Lowy's method of therapy in cases of chronic lead poisoning?

Dr. Otto Lowy: In reply to Dr. Goldstein, I shall say that the question of treatment in lead poisoning depends largely upon the length of exposure and upon the amount of lead which has been fixed in the bones, and also upon the extent of the lead stream which is found in the circulating blood. If there is a lead stream in the circulating blood and if the patient has active and acute symptoms such as the doctor has spoken about, that is, the lead colic, then the best method of treatment is intravenous injection of calcium gluconate which immediately fixes the lead in the bones. It combines with the lead forming a dicalcium lead phosphate, which fixes itself in the bones. It removes the lead stream and, by removing the lead stream, removes the irritating effect which the lead has or seems to have upon the celiac ganglion, which in our opinion causes the lead colic, with the prompt disappearance of the acute symptoms; then it is a question of gradually eliminating the lead by means of either phosphoric acid drinks or ammonium chloride or substances which change the pH of the blood. That should be done slowly and cautiously; otherwise a new attack of lead intoxication will be precipitated.

I may say that one of the reasons why we do not do a quantitative estimation of lead in the urine is that as far as the prognosis in the case is concerned, as far as the treatment of the case is concerned, the amount of lead present in the urine is of absolutely no significance. The Lederer test is a rather crude test. It does not show amounts of

lead as small as 0.08, that is eighty-one-hundredths of a milligram of lead, in 1000 c.c. of urine. Quantities as low as that do not produce lead poisoning, so I say that when lead is found in the urine by means of the Lederer test, or by means of the quantitative test, it simply means that the individual has absorbed or ingested lead.

I believe that Dr. Goldstein's suggestion is important, and that efforts should be made to prevent manufacturers from putting on the market toys that are painted with lead paint or that in any way contain lead that children may eat or ingest.

PREOPERATIVE TREATMENT IN GYNECOLOGY

William J. Carrington, M.D., F.A.C.S.,
Gynecologist, Atlantic City Hospital,
Atlantic City, N. J.

Much has been written, of late, about postoperative complications. Comparatively little has been said about preoperative care, yet the prevention of most complications rests on the careful preparation of the patient before operation. What has been written on this subject has appeared, for the most part, in books and magazines written by and for gynecologists. As a matter of fact, however, the bulk of the preoperative treatment can be carried out by the general practitioner. If he fails to do this he not only neglects a source of considerable income, but what is worse, he may lose the confidence of the patient and her friends. It is not uncommon for a woman to be admitted for an operation of election, only to find out for the first time that she has an easily discoverable condition which contraindicates any operations except those clearly life-saving in character. The time element does not enter into the preparation of gynecologic cases with the exception of such emergencies as ruptured ectopic gestation. All others have the right to meticulous preparation. Of what does proper preoperative treatment consist?

(1) Every woman is entitled to a *full and exhaustive history*. Careful questioning may reveal the fact that the symptoms are not really due to pelvic trouble at all, but are merely local manifestations of a systemic condition. The history may, furthermore, unearth positive contraindications to operation. If the patient has undergone a previous operation, her history should include a record of the findings; and, of course, the history should include a detailed account of the complaints. It is more than a matter of satisfaction to have these recorded when and if the patient returns after operation complaining of the persistence of symptoms. It is human nature to forget the many symptoms which have been entirely relieved, and to recall the one which persists.

(2) Every patient is entitled to a *complete physical examination* for reasons so obvious as to preclude argument; yet such an examination by the general practitioner is the exception rather than the rule.

Not infrequently, examination may reveal serious conditions which contraindicate, or at least complicate, pelvic surgery. Some of the more important of these are discussed below.

Vascular System

(1) *Valvular disease of the heart* in itself is not a contraindication to operation. Patients with compensated mitral disease, even with fibrillation, tolerate operation under ether anesthesia fairly well.

(2) *Syphilis of the aorta* with aortic regurgitation is serious, but operation is reasonably safe if there is compensation.

(3) *Aneurysm* is a contraindication, but smooth dilation of the arch is not.

(4) *Myocardial insufficiency* is a serious contraindication. Compensation must be attained and then the electrocardiograph, the internist's opinion and the urgency of the case determine what operation, if any, is to be done, and what anesthetic is to be chosen. Many writers believe that uterine fibroids predispose to fibrotic changes in the heart muscle, and that, therefore, removal of the fibroid will benefit the heart. The majority of pathologists, however, do not believe that there is any connection between the 2 conditions. It is true that autopsy reveals fibrosis of the myocardium in many cases of sudden death from fibroids.

(5) *Arteriosclerosis* in elderly women is a common preoperative finding. The question of operation depends upon the condition of the coronary vessels, and upon the involvement of the Malpighian tufts. The indications for

operation must be weighed carefully, and if possible, palliative treatment instituted.

(6) *Essential hypertension* is not serious from an operative point of view. It is better to reduce high blood pressure to the patient's physiologic normal, if possible, though operation has been performed without the slightest disturbance in patients with a systolic pressure of 250 and over.

(7) *Phlebitis* caused by the pressure of large pelvic tumors is not uncommon. Because of the danger of embolism, no operation should be attempted until the patient is afebrile and the thrombus firmly organized.

(8) *Digitalis.* The routine use of digitalis before operation has been suggested, but there is no convincing evidence that promiscuous preoperative digitalization fortifies the normal heart; and with this procedure there is always the danger of digitalis intoxication.

Urinary System

(1) *Nephritis*, acute or subacute, contraindicates general anesthesia including avertin. If operation is imperative, local or spinal anesthesia is indicated.

In chronic nephritis the degree of renal involvement, the internist's advice, and the urgency of the indication are the factors which decide the type of both anesthesia and operation. An abundance of albumin and casts, retention of nitrogenous products in the blood, a fixed specific gravity, and a lowered phthalëin output mark the patient as a poor risk. The ability of the kidney to excrete phenolsulphonphthalëin does not actually correspond to its ability to excrete normal substances. About 50% of the glomeruli must be disabled before diminution of the dye can be detected. For this reason, positive findings have more value than negative.

It must be remembered that a large tumor may press on one or both ureters, aggravating the nephritis. In such a case, the nephritis is improved by removing the tumor.

(2) *Urinary tract infections* should receive treatment, particularly before plastic work, as infected urine, pouring over the operative field, is likely to infect the wound. However, it is almost impossible to clear up the pyuria of a cystocele until the cystocele itself is repaired.

(3) *Prophylactic doses of urinary antiseptics,* such as urotropin and pyridium, may well be given a few days before operation in perfectly normal cases, in order to prevent postoperative "catheter-cystitis".

Respiratory System

(1) Acute coryza should command wholesome respect, and should contraindicate general anesthesia. Operation should be postponed, if possible, for a month. If the case is urgent, the patient should be given large doses of atropine, and operated upon under nitrous oxide or spinal anesthesia.

(2) *Chronic nasal catarrh,* including sinusitis, seems to offer no hazard.

(3) *Acute tonsillitis,* like acute coryza, should cause the postponement of an operation if possible. If the urgency of the condition necessitates immediate operation, spinal anesthesia is warranted.

(4) *Chronic tonsillitis* calls for the emptying of the crypts, the application of silver nitrate or argyrol, and the use of antiseptic gargles for a few days before operation.

(5) *Chronic non-tuberculous pulmonary diseases,* such as bronchitis, emphysema and bronchiectasis, are serious. The anesthesia should be local or spinal, and the indication for operation should be most urgent. A woman with any pulmonary disease is likely to have a stormy convalescence, and may develop a postoperative pneumonia.

(6) *Pulmonary tuberculosis* contraindicates elective surgery. Unrecognized incipient tuberculosis may be lighted up and become acute and even miliary. In healed tuberculosis, necessary operations are done as quickly as possible under local or spinal anesthesia in order to avoid pneumonia, or worse, the relighting of the old process.

Disorders of the Blood

The preoperative examination of the blood may reveal important information.

(1) *Anemia* is frequently encountered in women seeking relief from pelvic disease.

(a) *Pernicious anemia* is rare in women, particularly in colored women. In the pres-

ence of active pernicious anemia, only life-saving operations should be performed until, by proper treatment, the hematologic picture can be restored to normal.

(b) In *secondary anemia,* patients with hemoglobin below 50% are poor risks, particularly if the anemia is of long standing. If the hemoglobin is 50% or below, or if the red cell count is 2,500,000 or less, the preoperative treatment should consist of a high purin diet, iron and arsenic injections, and even blood transfusion. When indication for operation is urgent, blood transfusion should be done. If a suitable donor is not available, 25 to 100 c.c. of 50% glucose should be administered intravenously. Glucose temporarily improves the quality of the pulse by improving the ventricular filling of the heart; temporarily raises systolic blood pressure 15 to 50 m.m. in 4 to 5 minutes, and produces a peripheral circulation by its osmotic effect on tissue fluids. It temporarily lowers body temperature; increases clotting time in all patients except those suffering from jaundice; combats acidosis; and finally prevents agglutination of blood. In addition, glucose serves as a food for the vital organs, especially the liver and heart muscle; produces diuresis; and increases the protective power of blood by increasing myelocytes.

(2) *Leukocytosis*: If the increase in leukocytes is due to leukemia, the latter is more urgently in need of treatment than almost any gynecologic condition. If the leukocytosis is due to inflammation, it is better to keep the patient at home with ice bags over the lower abdomen, and to give hot vaginal douches until the temperature, the leukocytosis, and the sedimentation time have subsided. This rule holds good in both gonorrheal and streptococcic pelvis inflammatory disease, the exceptions being Bartholin's abscess and pelvic abscesses; both of these should be incised and drained. The pelvis abscess should be drained through the cul-de-sac, and not through the peritoneum.

(3) *Syphilis*: A positive Wassermann, in itself, does not contraindicate a gynecologic operation. Primary or secondary syphilis is dangerous to the operator. Except in extreme emergencies, patients with open luetic lesions should have anti-luetic treatment before operations. One or 2 full doses of neoarsphenamine will render the lesion innocuous to the surgeon.

(4) *Dehydration* due to protracted vomiting, diarrhea, or any other cause makes the patient a poor risk because dehydration kills by interfering with the migration of erythrocytes through the capillaries of parenchymatous organs, thus preventing tissue respiration. Fortunately, this condition can be corrected rapidly by fluid administered by mouth, under the skin, by rectum, or intravenously.

(5) *Coagulation time* is not important in gynecology except in the presence of jaundice. In jaundice, intravenous injections of 10 c.c. of 10% solution of calcium chloride daily for 2 or 3 days usually brings the coagulation time within the safety zone. When it fails to do so, whole blood transfusion should be used.

(6) *Disturbance of acid-base equilibrium*: The ordinary preoperative maneuvers give us no hint as to what cases will show disturbances of the acid-base equilibrium. Formerly, when preparation for operation meant long preliminary starvation, one saw that form of acidosis known as ketosis. We now feed our patients until the morning of operation. Diabetics and potential diabetics (patients with low sugar tolerance) make one apprehensive, and such patients should have bicarbonate of soda for several days prior to operation. If in doubt, determine the carbon-dioxide-combining-power of the plasma by the Van Slyke method. The prophylaxis of disturbances of acid-base equilibrium is as follows: (a) Reduction of preoperative starvation to a minimum. (b) Maintenance of water balance, and prevention of dehydration. (c) Parenteral administration of dextrose when adequate nourishment cannot be tolerated by mouth. (d) Blood transfusion if much blood has been lost.

(7) *Sedimentation time*: The speed at which the patient's erythrocytes settle in the presence of an anticoagulant is of the utmost importance in determining the most favorable time for operating on cases of pelvic inflammatory disease. We have used this test for the past 5 years and have come to rely upon it. The sedimentation test, the temperature, and the leukocyte count form a tripod upon which one can base an accurate opinion. If there is active or rapid sedimentation time even with

a normal temperature, and a normal leukocyte count, operation will, in all likelihood, be followed by unfavorable reactions.

Gastro-Intestinal Tract

(1) *Oral sepsis* is considered by some, a contraindication to operation. Certainly, gross foci of infection should be cleared up, not only for the patient's general welfare, but also to prevent postoperative parotitis.

(2) *Diarrhea* is not due to a gynecologic condition, except through rupture of a pelvic abscess into the bowel. Usually, diarrhea is due to a disease of the intestinal tract, and should be treated before operation.

(3) *Obstipation* also, as a rule, results from non-gynecologic disease. I have seen no relief from constipation follow correction of retroversion of the uterus, and it is a mistake to promise relief. If the obstipation is caused by intestinal obstruction, the treatment of that condition is vastly more important than the treatment of the associated pelvic disease.

Skin

(1) A patient with generalized *furunculosis* is a poor operative risk. Boils on the abdomen or perineum may infect the operative wound. In generalized furunculosis, staphylococci gain entrance to the blood from time to time, and may set up dangerous suppuration in the wound, if not a fatal staphylococcemia.

(2) *Dermatitis, pruritus and eczema* should be treated locally before incising through an affected area. An exception to this is the dermatitis of the vulva, buttocks and thighs, due to leukorrhea.

(3) In *leukorrhea,* due to cervical disease, hot antiseptic douches 2 or 3 times a day, puncture of the cysts of Naboth, and application of 10% silver nitrate solution are indicated for a week before operation.

Glandular System

(1) *Hyperthyroidism* is a serious complication. If the patient has both a pelvic disease and hyperthyroidism, the latter usually needs attention first. Occasionally, toxic goitres are aggravated by pelvic infection which must be relieved. but these patients are poor risks. They are best treated before operation by rest, ice collars and x-ray. These cases require good team work between the internist and the gynecologist.

(2) *Obesity,* if marked, is a handicap to the gynecologist, to the nurses and to the patient. Fat abdominal walls are easily infected, and pulmonary embolism, heart failure and sudden death are more frequent in the obese. It is safer to delay operation, if possible, until the obesity is corrected.

(3) *Emaciation*: Insulin, and a forced carbohydrate diet may be used in non-diabetics. Forced feeding, tonics and particularly fluids are indicated.

(4) *Menstruation*: During menstruation the tissues are more vascular. However, hemostasis is no more difficult, nor is convalescence less smooth, if a woman is operated upon during the catemenia. But, there is a popular belief that women, if operated upon while menstruating, either die or have a stormy recovery, and it is just as well to respect this belief unless the need for surgery is urgent. Four to 10 days after menstruation is, perhaps, the best time to operate.

(5) *Diabetes* is a serious complication. Occasionally pelvic pus must be liberated because of the harmful effects of its toxins on the islands of Langerhans. Operations on the diabetic call for team work between the gynecologist and the internist. This team work must continue through the postoperative period. Sugar, acetone and diacetic acid should be removed from the urine, blood sugar reduced, and the patient fed, with or without insulin, in order to give her as much strength as possible.

Nervous System

The genital and nervous systems are so closely interrelated that there is a confusing commingling of symptoms, and the clinical picture is often blurred. Disturbances of internal secretions may explain many of these phenomena. It is certainly true that the gynecologic treatment of nervous patients is a difficult problem. Fortunately, it is not important to determine whether the subject is a gynecologic patient with nervous symptoms, or a nervous patient with gynecologic symptoms. In either group, the indications for operation are the same, namely to control: (a) Blood loss;

(b) toxic poisoning; (c) pressure symptoms on the ureter, pelvic viscera, or adhesions to the bowel causing obstipation. In some cases, the mere knowledge of pelvic disease without other symptoms, keeps the patient in constant apprehension. Such a patient may need operation. It is better for her to be uninformed of the presence of the pelvic disease, but the condition should be explained to a responsible relative.

Nervous women, above all others, should have their preliminary studies made at home. Their preoperative stay in the hospital should be as short as possible. Local preparations are best postponed until the patient is anesthetized, and avertin is the anesthetic of choice.

Doctors are likely to have little patience with the anxieties and minor problems of nervous patients in advance of operation. Yet these same doctors gladly welcome the comfort of the utmost consideration of their own preoperatvie whimsicalities.

Conclusion

Gynecologic operative treatment consists of: (1) Preoperative preparation; (2) the operation itself; (3) postoperative care.

Of the 3, the preoperative treatment is by far the most important; yet it has received less consideration than the technic of the operation, or the postoperative care. Careful preparation of the patient can be and usually should be carried out by the general practitioner before the patient enters the hospital. Proper preoperative care presupposes a careful history, and a painstaking physical examination. If either is neglected, both the doctor's reputation and the patient's welfare are likely to suffer.

SCARLET FEVER IMMUNIZATION BY INUNCTION

A Preliminary Report

Maurice L. Ripps, M.D.,
Elizabeth, N. J.

An efficient reactionless method for scarlet fever immunization has, as yet, not been perfected. Although the use of raw toxin in graduated doses has shown an efficiency of 90 to 95%, the reactions have been so severe and so common that it has been largely discontinued. A resort to a detoxified toxin paralleling the diphtheria toxoid technic of Ramon naturally followed. Sparrow and Celarek, Ramon and Debre, Veldee, McMahon, and Futagi, all reported a high degree of immunization and a marked decrease in both the frequency and severity of reactions following the injections with anatoxin. As yet, however, these results have not been uniformly obtained, and one hesitates to suggest this preventive measure until he feels assured it will be relatively free from discomfort, in order that, when widely used, it will receive no set-backs in gaining the general acceptance of the public.

Lowenstein's reports on immunization with diphtheria toxin by the percutaneous method, followed by substantiating results of others, naturally lead to a similar attempt with scarlet toxin. E. E. Martmer has presented a communication which is, I believe, the only previous study of this method of immunization applied to scarlet fever. He used Dick toxin mixed with anhydrous lanolin, so that each 2 c.c. of ointment contained 25,000 skin test doses. Five applications were made, one group receiving their massages every second day, the other group at 5-day intervals. In the latter group the backs of the patients were rubbed vigorously for 5 minutes; of these children, more than 90% were immunized at the end of 6 months. His paper was the direct stimulation for the one I am now presenting.

Several diversions from the main thesis of this report will be made in order to offer more accurate means for comparing my results with that of others who may have had better facilities and abilities for carrying on this work.

General Data

A total of 484 children, ages 1 to 16, were tested; of these, 147 were Dick positive. Most of these children (420) were residents of 4 orphan institutions; most of the remainder were obtained from my own practice. The inverse relationship between age and susceptibility was strikingly demonstrated:

Ages 1 to 4—73% positive
4 to 6—44% positive
6 to 10—18% positive
11 to 16—11% positive

Only reactions of at least 1 cm. were considered positive. To gage the results more accurately these positives were further divided into 1+, 2+ and 3+ groups, according to the extent of the reaction. The test was read in from 17 to 25 hours and, in most cases, more than one reading was obtained. As a general rule, there is no appreciable difference in a reading obtained anywhere from the eighteenth to twenty-fourth hour. Our tests were usually made with both the N. Y. 2 and the N. Y. 5 (Dochez) strains. As we found that our subjects were, as a rule, more sensitive to the Dochez strain (about 4%), our results are based only on the toxin prepared from it.

Preparation and Administration of the Inunction

The entire preparation of material was accomplished by the New York City Biological Laboratories. Two different bases were used: one, a plain cold cream; the other, anhydrous lanolin (after Martmer). Dick toxin, prepared from the N. Y. 5 (Dochez strain) of a potency of 24,000 S. T. D. was mixed with 2 c.c. of each base. Each child was given 5 massages over the entire back at intervals of one week. Preceding the rubs, the backs were cleansed with alcohol. For the first 2 rubs approximately 24,000 S. T. D. of toxin were used, and approximately 28,000 for each of the last 3 rubs. Gloves were used only for the first rubbing; after this the bare hand was used, some allowance being made for absorption. In those patients on whom the lanolin base was used, the backs received 6 to 7 minutes of brisk rubbing. In the cold cream group, only 2 minutes of rubbing was necessary.

Reactions

There were absolutely no general systemic reactions of any kind. About 20% of the children showed a mild dermatitis over the parts rubbed after the first application. This was often associated with itching. With the succeeding massages, the skin reactions were less frequent. At no time was the dermatitis distressing and the eruption usually disappeared within 2 days. Most of the children were not aware of any skin reaction for they actually complained of itching in only a few instances.

Results

One hundred and twelve positive children completed the rubbings and were tested. A few were tested at 2 weeks, and some at 6 weeks. All were retested 18 to 19 weeks after the last inunction.

These children were divided into 2 groups; the first group, consisting of 75 children, received the cold cream inunction. The second group of 37 children received the anhydrous lanolin inunction.

(A) Group I (cold cream)
No. of children 75
No. rendered Dick negative..... 46
Immunized 66%

Group II (Lanolin)
No. of children 37
No. rendered Dick negative 11
Immunized 30%

(B) Dividing both groups according to age, we find:
(1) Under 6 yrs.
No. of children 44
No. rendered negative 18
Immunized 45%

(2) Over 6 yrs.
No. of children 63
No. rendered negative 36
Immunized 57%

(C) Of 34 who were classified as "3+ reactors", only 9, or 26%, became negative.

Summary and Conclusions

(1) Of 112 Dick positive children completing treatment, 57 (56%) were rendered negative 18 to 19 weeks after the last inunction.

(2) Cold cream inunction proved superior to lanolin in that it was pleasanter to handle, quicker to absorb, and productive of a larger percentage of immunizations.

(3) The children who gave the most marked reactions to the Dick test were the most difficult to immunize (26%).

(4) Although our technic varied somewhat from Martmer's, we are not able adequately to account for the wide discrepancy in results. It has been suggested that if we had rubbed the backs more vigorously with alcohol or benzene as a preliminary to the inunctions, a higher degree of toxin absorption

might have been obtained. This will be considered in future studies.

(5) In children 1 to 4 years of age, our results were very poor; only 33% of the subjects in this group were rendered negative.

(6) A higher percentage of immunization may, perhaps, be obtained with increasing dosage. As much as 90,000 S. T. D. of toxin has been given to a group without any reaction. This will be reported in a subsequent communication.

(7) Because of the ease of administration and lack of reaction, a continued study of this method of immunization should be made.

I wish to extend my appreciation to Dr. William H. Park and to Mrs. Kolchin and to their staff of the New York Biological Laboratories for their most pleasant assistance. I also want to thank Burroughs Wellcome and Company for their coöperation in supplying the bases used in this work.

DISCUSSION

Dr. F. W. Lathrop (Plainfield): This work of Dr. Ripps' is very interesting and should certainly be carried on with further studies. I am one of the tender-hearted pediatricians. I believe most of us have felt that the scarlet fever immunization has shown such relatively severe reactions from the toxin antitoxin, that we haven't felt it justifiable to advise it for our patients. I think 56% is very encouraging and with further improvement in the preparation of the technic, we may have a preparation that will prove very valuable. I should like to ask Dr. Ripps if it is available to the general profession as yet or whether it is commercially available.

Dr. Joseph Schapiro (Union City): I think Dr. Ripps should be commended on the diligent work he has done. Certainly if this method proves efficient, a great advance will have been made, but not too much should be expected now. I should like to ask if he has any idea as to how long the children remain Dick-negative or how long immunization is effective, and whether it has been determined that the children who have not been Dick-tested can be made to become Dick-negative later.

Dr. Frank C. Johnson (New Brunswick): I should like to ask Dr. Ripps if he can give us the figures on the percentage of change from positive to negative Dick tests by the usual method of 5 doses of toxin, and explain the use of one strain of streptococcus in preparing toxins. Being ignorant of the subject, I did not appreciate the fact that the toxins used in immunization were not polyvalent and made from a number of strains of streptococci. One commercial laboratory with which I am familiar uses up to 30, or 40, strains of streptococci in their sera.

From Dr. Ripps' paper it also appears that the effect in the cases in which we desire effect—"3+ reactors"—is almost nil. That makes us who are very reluctant to use streptococcus preparations in scarlet fever, question its use more than we have in the past.

Dr. Maurice L. Ripps: Dr. Schapiro asked whether or not we can still expect some of these positives to become negative. Inasmuch as these tests were done 18 to 19 weeks after the last rub, it is possible that the immunization or the formation of the antigenic reaction in the body may take a longer period than 19 weeks and that some still may become negative; at least I hope so.

Dr. Martmer did his tests 6 months after the last rub; however, on the advice of Dr. William Park of the New York Board of Health, we tested these children at a very early period, expecting, of course, to continue our tests.

Scarlet fever antitoxin, as a rule, gives a quick reaction. Within 2 to 3 weeks you get most of the negatives as high as 90 to 95%, when treated by the intramuscular route. At 6 weeks, when we tested 20 children, we had 8 children negative. At 19 weeks, only 9 were negative, so that there doesn't seem to be a great increase in the number that become negative between the sixth and nineteenth week. I don't think many more of the children will become negative under the present doses.

Dr. Lathrop, your question, I believe, was whether the preparation was available. It is not yet available. We have only begun the work and it will probably be some time before we would even consider mentioning it to the commercial houses. The results will have to be much better than we have so far obtained.

Dr. Johnson, of course, refers to the really positive reactors, the 3+ reactors. Saying that it throws cold water on the proposition is putting it mildly. As a matter of fact, to me it threw a couple of cakes of ice. We had only 28% "takes" in children who were 3+ reactors, but even 28% is something; at least it shows we can get some immunization and, if carried on further, we may get somewhere.

Dr. Schapiro spoke of the duration of immunization. As yet we can't say. We haven't followed it long enough to know how long it will last. We know every child negative at 6 weeks was negative at 4½ months.

Dr. Johnson's other question is rather difficult to answer in percentages because that involves a particularly keen piece of work.

Mrs. Kolchin, of the New York Biological Laboratories, gives it as her opinion that the Dochez strain toxin will probably develop an antitoxin for at least 90 to 95% of the known strains of streptococcus hemolyticus.

With the raw toxin they get as high as 90 to 96% of immunizations. Of course, as we have noted, the immunizing under these conditions is worse than having the disease. The detoxified preparation in which some formalin has been added, gives almost a similar number, probably a little smaller percentage of immunization with a marked decrease in the number of reactions, but still enough reactions to prevent us from using it generally.

Chairman Johnson: I apologize to Dr. Ripps because I misheard his statement of 3+ reactors. I thought he said 5%. Twenty-eight per cent is very good.

DEATH RATES OF THE NEW JERSEY STATE HOSPITAL AT MARLBORO

Fiscal Year Ending June 30, 1933

Howard G. Borden
Statistician,
Marlboro, N. J.

The New Jersey State Hospital at Marlboro, although now operating as a full-fledged institution, is still in the process of construction. When the hospital received its first patients on February 7, 1931, only one building was habitable, service facilities were almost nil and there were no facilities for the care of disturbed patients. The first 1500 patients were, therefore, transferred from Greystone Park, Trenton State Hospital and from the Essex County Hospital, as these institutions were badly overcrowded. These patients were selected because they were stable, institutionalized cases, who were able to walk to their meals. Naturally, with such a unique population, drawn from the chronic wards, the ordinary measures of comparison, namely death rates, discharge rates and recovery rates were wholly unsatisfactory and new methods of comparison had to be found.

The first of these measures is that of the deaths during the fiscal year ending June 30, 1933. As a measuring stick for this there were Malzberg's "Life Tables for Patients with Mental Disease".* These gave death rates by age groups and sex for patients in the New York State Hospitals and for the civil population of the state for 1930. Multiplying the population of Marlboro by these rates gave the normal (New York) expectancy which could be easily compared with the actual deaths at Marlboro.

Table I shows the age groups in the population on June 30, 1933, compared with the percentage distribution in all hospitals for mental disease in the United States on January 1, 1923. The concentration at the middle ages will be noticed.

TABLE I

Distribution of Population of Marlboro State Hospital by Age Groups

June 30, 1933

Age Group	Males			Females		
	Population	% Dist.	U. S. % Distribution	Population	% Dist.	U. S. % Distribution
Under 15	0	0.0	0.3	1	0.2	0.2
15-19	8	1.0	1.4	3	0.5	1.2
20-24	22	2.6	4.8	20	3.4	3.2
25-29	62	7.4	8.5	39	6.6	6.5
30-34	75	8.9	11.2	68	11.6	9.3
35-39	86	10.2	12.5	94	16.0	11.1
40-44	118	14.0	12.3	94	16.0	12.0
45-49	129	15.3	11.3	85	14.5	12.1
50-54	111	13.2	10.1	70	11.9	11.5
55-59	83	9.9	8.5	47	8.0	9.5
60-64	51	6.1	7.3	40	6.8	8.5
65-69	55	6.5	5.3	16	2.7	6.0
70-74	23	2.7	3.5	5	0.8	4.2
75-79	14	1.7	1.8	2	0.3	2.7
80 and over	4	0.5	1.2	0	0.0	2.0
Unascertained	5					
Total	846	100.0	100.0	588	100.0	100.0
Average age—Marlboro	47.2 years			44.3 years		
Average age—U. S. Hospitals	45.9 years			48.5 years		

The next step in the process is the reduction of the June 30th population to the average for the year. The actual average population was 726.6 males and 507.9 females. This assumes that the age distribution at the end of the year is representative of the distribution throughout the year. The third step is the multiplication of the population groups by their respective rates from the Malzberg tables. This gives the number in each group that we might have expected to die if New York State Hospital rates or New York civil population rates applied at Marlboro. By adding the groups, we

*Jour. Am. Statistical Assoc., March 1932 Supplement, pp. 160-174.

TABLE II

MALZBERG TABLES APPLIED TO MALBORO AGE GROUPS

Age Group	Males					Females				
	Average Popul.	Rates per 1000 Hosp.	Rates per 1000 Civil	Expectancy Hosp.	Expectancy Civil	Average Popul.	Rates per 1000 Hosp.	Rates per 1000 Civil	Expectancy Hosp.	Expectancy Civil
15-19	6.9	52.0*	5.0*	.36	.03	0.9	60.0*	5.0*	.05	.00
20-24	19.0	45.51	5.38	.87	.10	2.6	55.78	5.28	.16	.01
25-29	53.5	35.82	6.27	1.92	.34	17.4	51.02	6.60	.97	.09
30-34	64.8	38.26	7.39	2.48	.48	33.9	42.51	6.74	1.73	.22
35-39	74.3	43.82	8.41	3.26	.62	59.2	40.80	6.73	2.51	.40
40-44	102.0	52.13	10.04	5.32	1.02	81.7	45.35	8.11	3.34	.55
45-49	111.4	59.56	12.69	6.65	1.41	81.7	47.83	10.66	3.71	.66
50-54	95.9	72.77	17.11	6.98	1.64	74.0	54.99	14.40	3.54	.79
55-59	71.7	88.92	24.83	6.36	1.78	60.9	68.49	21.42	3.35	.88
60-64	44.0	113.92	34.53	5.02	1.52	40.9	90.20	29.64	2.79	.88
65-69	47.5	171.58	50.09	5.59	2.38	34.8	122.08	46.70	3.13	1.03
70-74	19.9	267.28	73.08	5.31	1.45	13.9	171.86	69.40	1.70	.65
75-79	12.1	337.95	105.93	4.10	1.28	4.4	241.47	98.63	.76	.30
80+	3.5	436.50	156.03	1.53	.55	1.7	334.23	140.30	.41	.17
Total	726.6			55.75	14.60	507.9			28.15	6.63
Actual deaths				17	17				4	4
Ratio of actual to expected				30%	116%				14%	60%

	Hospital	Civil
Total male and female expectancy	83.90	21.23
Total actual deaths	21	21
Ratio of actual to expected	25%	98%

*Estimated. Not given in tables due to small numbers invloved.

obtain the total expected deaths which can now be compared with the actual deaths. Table II shows these steps.

We thus find the death rate at Marlboro to be only one-quarter of that of New York Hospitals for Mental Disease and better even than the rate for the general population of New York State. Evidently the active work of the hospital staff is beneficial at least to the general health of the patients and it is believed that further studies will show equally good results in the mental health of the patients.

A REQUEST FROM THE SECRETARY OF THE SOCIETY

Dr. J. B. Morrison, the Secretary of our State Society, is preparing a list of medical families in New Jersey, where two or more generations or two or more members of one family have been engaged in the practice of medicine. This material will be stored away in the archives of a Medical History Club to which Dr. Morrison belongs, so that any historian in the future, who carries the history of medicine in New Jersey beyond this point, will have such authentic data at hand.

Letters have been written to the known members of such families in New Jersey, but doubtless there are many others. Those physicians who are interested, and who have such information, will please send the following data to Dr. Morrison, at 66 Milford Avenue, Newark, N. J.:

Name .....

Born at ..... Date .....

Died at ..... Date .....

Graduated from (University or College) .....

Date .....

Practiced in ..... for ..... Years

Practice limited to .....

Medical Honors or Appointments .....

Civil Honors or Appointments .....

Served in Civil, Spanish-American or World War .....

Rank .....

Current Events

THE PUBLIC HEALTH PLAN EXPLAINED TO THE NATIONAL CHILD HEALTH RECOVERY CONFERENCE

October 6, 1933, at Washington, D. C.

Dr. Stanley H. Nichols, Chairman of the Public Health Committee of the Medical Society of New Jersey, appeared before the National Child Health Recovery Confcrence and outlined the comprehensive Public Health Plan developed by the medical profession of New Jersey through its State organization.

Dr. Nichols placed special emphasis upon those features of the Plan which concern child health conservation, and showed how it can serve the needs of the Child Health Recovery Conference.

The introductory remarks of Dr. Nichols follow:

"Some of us in the Medical Society of New Jersey are organizing *all* of New Jersey's *health professional workers* for *real teamwork* in Child Health and Public Health Service, and are positive that, while the *quarter-back* of this health team may be the trained health (or relief) administrator, the fullback *must* be the organized medical profession, educated to take responsibility for public health problems such as those which face this Conference.

The physician, collectively speaking, is the *Senior member* of this health team of hospital workers, nurses, dentists, pharmacists, health officials, social and welfare workers, and, most recent of all, emergency relief officials. The physician is now prepared to add the public health problems of his county and state to his past burden of providing individual curative medical service. He asks the coöperation and assistance of the rest of the health team.

I will very briefly present the Public Health Plan of the Medical Society of New Jersey under three headings: (1) Development; (2) present set-up and objectives; (3) how the plan and set-up can be used to survey and meet the needs of children as defined by this Conference.

Development of the Plan

During the proceedings of the Public Health Section of the New Jersey Child Health Conference in 1931, it became glaringly obvious that the many public and private agnecies serving child health in the State were each doing excellent work, but with little or no coördination. Moreover, integration of the organized medical profession was largely missing.

Therefore, some of us in the Public Health Section of the Conference requested the State Medical Society of New Jersey to appoint a Public Health Committee to try to accomplish this coördination, and link the organized medical profession to it."

At this point, Dr. Nichols stated that such a committee was appointed in 1931, and then gave its personnel as organized at the present time. Continuing, Dr. Nichols said:

"Thus, in this Committee, we have the teamwork of practicing physicians and the medical chiefs of the state health, education, institutional and other departments dealing with child health.

This Committee created the following 1932 and 1933 plans:

In 1932 it produced the 'Principles of working relationship between state and county medical societies and boards of health, child hygiene activities, school health programs, hospitals, hospital clinics, and health and welfare organizations.' These were adopted by the State Society.

It then created a Public Health Committee in each of the 21 component County Medical Societies of the State, and assigned each member of the State Public Health Committe to be responsible for the development of the Public Health Plan in 4 County Societies and assist the Public Health Committees of those 4 Socicties in carrying out the Plan.

The 1933 Plan presented by the Committee, and adopted by the State Medical Society in June 1932 has 3 specific objectives:

(1) Diphtheria Immunization of children between the ages of 6 months and 6 years, preferably before the age of 2.

(2) The Health Supervision of the pre-school child by the family physician and by (a) a bi-annual examination on the New Jersey Pre-School Record Form (supplied by the Committee); (b) recommendations as to active measures for health improvement and general health supervision of the pre-school child by its family physician.

(3) As a necessary working agency for the definite accomplishment of the first 2 objectives and of future health plans, the setting up by the County Medical Societies, of County Medical Society Health Service Committees. These Committees to consist of its Public Health Committee and representatives of all existing health agencies in each county for the stated object of providing by existing health agencies adequate medical care for all people in each county as costs within their means."

As an example of the type of organization, Dr. Nichols described in detail the Monmouth County Plan. The members of the State Society are familiar with this particular plan. Dr. Nichols expressed his pride in the fact that Monmouth County is one of the 5 leading counties in the United States in public health standing.

Dr. Nichols then went on to say:

"Now, how can this personnel and set-up be used in New Jersey for (a) examining selected groups for the purpose of finding children suffering from malnutrition and borderline malnutrition, and (b) putting on a program for restoring them to good condition and correcting the physical defects found?

The Medical Society of New Jersey is *prepared to do this*, and in conjunction with the Child Hygiene Division of the State Department of Health, the Health Division of the Department of Public Instruction, the medical division of the State Department of Institutions and Agencies and other agencies dealing with child health, is ready to undertake this program in the State of New Jersey.

The largest and most feasible group to work with at first, I presume, is the New Jersey group numbering 200,000 of the 12,000,000 children of families on Relief Funds in the United States. The Medical Society of New Jersey in August 1933 signed an agreement with the New Jersey State Emergency Relief Administration through a Medical Relief Committee, to provide curative medical care for persons on Relief at approximately one-half the usual fees. The Medical Relief Committee of each County Medical Society is now enrolling the physicians to do this work.

I would suggest that the Federal regulations governing medical care of relief cases be altered

so as to allow a limited part of the funds to be utilized for the examination and improvement of the malnourished child on relief. I would suggest, further, that the Department of Labor through its Children's Bureau and the Federal Emergency Relief Administration, request the New Jersey Emergency Relief Administration to invite the Medical Society of New Jersey and the State Department of Health, through the Public Health Committee of the State Medical Society and the Bureau of Child Hygiene of the State Department of Health, to jointly organize and undertake responsibility for the New Jersey Child Health Recovery Program, formulated today by this Conference, on behalf of the children on relief. These two organizations could head up the program, and be responsible for it to the New Jersey Emergency Relief Administration, the Children's Bureau of the Department of Labor and the Federal Emergency Relief Administration. They could call on the Departments of Public Instruction, and of Institutions and Agencies, through their health representatives, and on such other State public and private agencies dealing with child health as may be found necessary, for the development of the program. Groups of malnourished children will be uncovered in the study who are not on Relief, and ways and means planned to meet their needs. The malnourished child can be *located* through: (a) the medical societies and health officers; (b) the public health nurses; (c) the State and local baby-keep-well stations; (d) group examinations of the *pre-school* child on relief; (e) by physicians in the school system; (f) by the County Medical Society doctors now being signed up for curative care of the families on relief.

An intensive program to restore these children to good condition and correct defects found, will be a large task but could be carried on by the same two organizations. Undoubtedly, it will assume some permanent form, as the problem, to some degree, will always be present in the future.

I wish to thank the Department of Labor, the Children's Bureau and the Executive Committee of this Conference for the opportunity of presenting the medical situation in New Jersey.

May I conclude by quoting from the telegram sent by our State Society President, Frederic J. Quigley, to Miss Grace Abbott, 'Believe Public Health Program from Society will be of positive value in contemplated movement. Be assured of the full coöperation of the Medical Society of New Jersey.' "

School Health Department

THE HEALTH EXAMINATION

Allen G. Ireland, M.D., Medical Director,
State Department of Public Instruction,
Trenton, N. J.

The Nurse's Part

The following activities are primarily those for which the nurse is usually responsible. The list is not necessarily exhaustive nor will it meet conditions in all situations.

(1) Overseeing the preparation of facilities and equipment for the examination.

(2) Arranging with principals and teachers for schedule of examinations, specifying dates and hours as accurately as possible.

(3) Having all records and report forms in readiness.

(4) Sending announcements and invitations to parents.

(5) Sending request letters for parental consent for removal of pupils' clothing.

(6) Consulting with the school physician regarding the division of work and the organization of the pupils.

(7) Conducting preliminary tests before the physician starts his part of the examination. The items covered by the nurse will vary according to local programs, but the following are some of those frequently assigned to her:

History taking	Lymph nodes
Skin and scalp	Feet
Hearing test	Speech defects
Vision test	Chorea, tic, habit spasms
Weight and height	Mouth-breathing
Posture	

(8) Meeting pupils at time of physician's examination and helping him to open, loosen, or remove clothing.

(9) Recording physician's findings on the individual record cards.

Presence of Teacher

The advantages of having the teacher present during the examination of her class are as follows:

(1) Facilitates the reporting and interpreting of the teacher's observations of pupil habits, mannerisms and signs and symptoms. It enables the physician to question the teacher directly concerning those observations and also about other things which the examination seems to reveal.

(2) Helps to bring about the factor of coördination that should be present in the relationship between the health and the academic services of the school.

(3) Gives emphasis and meaning to the health examination in the understanding of the teacher, insuring greater use of the school health service in discovering causes and needs.

(4) Enables the teacher to hear first-hand the recommendations of the physician and to inquire about anything not understood, thus giving a better insight into the correct management of a pupil in the classroom.

(5) Permits the teacher to give information he may have concerning the pupil's environment, home and play life, and past history.

(6) Permits use of the teacher for recording, preparing pupils, and introducing parents, thereby freeing the nurse to give tests or to help the physician in other ways.

(7) When parents also attend, the teacher not only has the opportunity for meeting them, but for gaining an insight into the home, family, and parental aspects of the pupil's developmental life.

There are no disadvantages to the teacher's presence at the health examination of his pupils, that are at all comparable in weight to the advantages.

Presence of Parents

The practice of inviting parents to the health examination of pupils is on the increase. Some of the advantages claimed are:

(1) Enables the physician to give a more thorough examination, since consent to the removal of clothing is usually obtained.

(2) Gives the physician an opportunity to inquire into the pupil's history, habits, and complaints and home conditions.

(3) Facilitates interpretation of findings to parents by giving opportunity for questioning and explanation.

(4) Brings together the principals—parent, phy-

sician, nurse, and teacher—concerned in the supervision of a pupil's health, growth, and development.

(5) The personal contact with parents seems to insure a higher percentage of corrections, and it creates a feeling of friendliness on the part of the parents.

Communications

A NEW ORGANIZATION

(A letter received from Dr. J. Gerendasy, Secretary of the New Jersey Gastro-Enterological Society, Inc.)

A society called the New Jersey Gastro-Enterological Society was formed and incorporated May 1, 1933. The object is to promote the investigation of normal and pathological conditions of the digestive organs.

The following officers were selected for the year 1933: President, Dr. S. Bernard Kaplan, Newark; Vice-President, Dr. Louis L. Perkel, Jersey City; Treasurer, Dr. Siguard W. Johnsen, Passaic; Secretary, Dr. J. Gerendasy, Elizabeth.

The society is rapidly increasing its membership, and it is hoped that eventually it will embrace the entire state. For information, address the Secretary, J. Gerendasy, 956 East Jersey Street, Elizabeth, N. J.

The first scientific meeting was held at the Academy of Medicine, Newark, October 9. Papers of the evening were:

(1) "Clinical and Roentgenological Study of 100 Cases of Constipation", Dr. Johnsen; discussion by Dr. Gerendasy.

(2) "Malignancy of the Gastro-Intestinal Tract in Young Adults with X-Ray Demonstration", Dr. Perkel; discussion by Dr. Burke.

BOARD OF MEDICAL EXAMINERS

(A letter received from the New Jersey State Board of Medical Examiners enclosed the following copy of decision rendered by the Supreme Court to whom this case was appealed. The 2 individuals prosecuted for violating the law were Mary Miller and Nancy Kehoe.)

Mary Miller, who is a licensed chiropractor, in addition to prescribing diets and medicine, used a radionic machine for the purpose of diagnosis and treatment in her practice.

NEW JERSEY SUPREME COURT

Nos. 204 and 205 January Term 1933.

Before Justices Parker, Lloyd and Heher.

"The prosecutors in these cases were convicted of violation of section 10 of the act to regulate the practice of medicine and surgery (1 Cum. Sup., p. 1872), and writs of certiorari were allowed to review the convictions. In substance the charges were practicing medicine and surgery without a license, Mary Miller being the principal and Nancy Kehoe her assistant in such practices.

Mary Miller has a license to practice chiropractic only. The proofs show that Mrs. Miller had an office and treating rooms at 327 Park Avenue, Paterson, with the sign "Dr. Mary Miller" on the window and the words "Dr .Miller" on the door mat; that she diagnosed the ailments of the witnesses and prescribed a diet of food and soda as a medicine, and administered electric treatments, which treatments were given also by Nancy Kehoe. Some of the treatments were for a fibroid tumor as diagnosed by Mrs. Miller, in which she changed the dressings; one for a cancer; and one for gallbladder and bronchial trouble. In one instance at least she directed the administration of opiates at the direction of a physician she called on the telephone. In addition to the foregoing, she advertised herself as Dr. Miller under the classified list of physicians in the city directory.

It is needless to say that under the authority of numerous cases, of which it is only necessary to cite that of State Board vs. Livesey, 140 Atl. 444, affirmed 105 N. J. L. 255, this constituted the practice of medicine without a license.

The prosecutors contend, however, that because the act of 1920 (P. L. p. 15) which defined "chiropractic" was repealed, there is no legal definition of the word and therefore the prosecutors were not offending. Even though the legislature has not since defined the word, this does not deprive it of all meaning and did not prevent a conviction in the Livesey case. The dictionary definition (Webster's New International) is "The practice of adjusting the joints, especially of the spine, by hand for the curing of disease".

It is next argued that Mrs. Miller was a graduate of an electro-therapeutic school and had practiced for 14 years prior to the adoption of Chapter 221 of the Laws of 1921 (p. 706), and that she came within the exception of section 9 of that act. It is sufficient to say that the proofs intended to invoke this exception were wholly insufficient. The school appealed to was not proved to be of "good standing" nor was Mrs. Miller practicing when the act was first passed in 1903. (Section 9, p. 495.)

The rules of the Board, if any, are not printed nor identified, so we cannot say that the court erred in their rejection.

The suggested unconstitutionality of the general act is not argued and perhaps wisely in view of numerous cases of this court and the Court of Errors and Appeals to the contrary.

The judgments are affirmed with costs."

Book Review

A delightful book, just published, is entitled *Jungle Memories* (McGraw-Hill Book Co.). The author is Dr. Henry H. Rusby, Emeritus Dean and Professor of Materia Medica, College of Pharmacy, Columbia University. Dr. Rusby is well known as an authority on drugs; to no small degree, the use of many valuable herbs as medicaments, is due to his pioneer investigations and discoveries.

Looking back over a well-spent life, Dr. Rusby puts down on paper his recollections of one of the many exploratory trips which he has undertaken over the past 50 years.

The book tells the story of his expedition to South America (1885-1887) in which he covered a vast area of the northern and western parts of that continent. The purpose of the trip was the scientific investigation of certain medicinal plants, notably coca leaves. A short time before, in an accidental way, the anesthetic qualities of its alkaloid, cocaine, had been discovered. The drug, however, was not in general use; the supply was extremely scarce. It was desired, further, to make a special study of the source of supply of Cinchona bark.

The trials and tribulations encountered by Dr. Rusby in his pursuit of these objectives are told in charming, dramatic style. A journey through certain parts of South America is exciting enough

today; a trip, 50 years ago, entailed even greater hardships. Despite the dangers associated with jungle travel, such as poisonous reptiles and insects, and almost impassable streams and forests, the trip was brought to a successful conclusion. Dr. Rusby on arriving home was so emaciated that his relatives and friends did not recognize him. As a result of the expedition, the supply of coca leaves was assured and, in consequence, the use of cocaine accelerated.

The busy physician will find in this volume a story, fascinatingly told, for his leisure moments. It will free his mind from clinical work for a short while; at the same time he should gain knowledge closely allied to his chosen profession.

A. E. S.

Woman's Auxiliary

Reported by Mrs. James North, Chairman of Publicity and Reporter to State Journal

Executive Board Meeting

The fall meeting of the Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey was held at the home of the President, Mrs. Harry Varsil Hubbard, in Plainfield, on Monday, October 9, 1933, at 10.30 a. m., with the President in the chair. In the absence of Mrs. H. H. Gillium, Mrs. James H. Mason, of Atlantic City, was Acting Secretary.

The minutes of the previous meeting were read and approved. It was moved and seconded that letters be sent to Mrs. Gillium and Mrs. William Gray. Mrs. H. Roy VanNess read the Treasurer's report. It was accepted as read.

The Chairman of Publicity and Reporter to the State Journal asked that County Chairman of Press and Publicity send reports of all meetings and 2 copies of all clippings of Auxiliary news on or before the nineteenth of each month.

Mrs. A. M. Schultz, Public Relations Chairman, recommended that every County Auxiliary have a Speakers' Bureau, composed of competent medical and lay men and women. A reciprocity meeting should be held each year, sponsored by the Auxiliary. Parent-Teacher Associations, Public Health Nurses' Association, Woman's Clubs, Y. W. C. A. and all such organizations interested in public welfare should be invited to attend.

The Hygeia Chairman, Mrs. Thomas P. McConaghy, urged every doctor's wife to read Hygeia.

Mrs. Theodore Teimer, Chairman of the Widows and Orphans Society, asks that each County Auxiliary work for larger membership.

It was moved, seconded and carried, to contribute $5 to the Yardley Foundation. Also moved and carried that the Auxiliary endorse resolution of the State Federation of Women's Clubs on Armament Conference. Mrs. Shaw was appointed to attend the Federation Meeting at Asbury Park October 11.

The meeting adjourned temporarily to enjoy a delicious luncheon as guests of Mrs. Hubbard.

Mr. Car Daines, Supervisor of Social Hygiene Education, State Department of Health, spoke on "Necessity of Being Educated to a Knowledge of Venereal Diseases".

An explanation and discussion of the year's program followed. Plan to get health work under leadership of physicians.

The January meeting will be in Trenton, January 8, 1934, the hour and meeting place to be announced later and every member of the Auxiliary is cordailly invited to attend. After a rising vote of thanks to Mrs. Hubbard for her gracious hospitality, the meeting adjourned.

Among those attending the meeting were: Mrs. H. V. Hubbard, Mrs. Frederick A. Kinch, Mrs. George L. Orton, Mrs. John Nevin, Mrs. Warren Duckett, Mrs. James North, Mrs. Don Epler, Mrs. James Mason, Mrs. James J. McGuire, Mrs. Theodore Teimer, Mrs. F. J. McCauley, Mrs. Connell, Mrs. H. H. Bolles, Mrs. A. J. Casselman, Mrs. George A. Rogers, Mrs. William Freile, Mrs. James Hunter, Mrs. H. Roy VanNess, Mrs. Charles B. Russell, Mrs. A. Dunbar Hutchinson, Mrs. Samuel L. Salasin, Mrs. A. M. Schultz, Mrs. T. P. McConaghy, Mrs. A. H. Lippincott, Mrs. A. L. Stillwell, Mrs. William A. Dywer, Mrs. Dan Renner.

Atlantic County

Anna M. Mally, Corresponding Secretary

The Woman's Auxiliary to the Atlantic County Medical Society met November 17 at the home of Mrs. Samuel Gorson. Mrs. Joseph Poland presided.

Mrs. Carl Surran, membership chairman, reported that many prospective members have been interviewed and have announced their intention of becoming active members after January 1.

Mrs. Daniel Reyner, entertainment chairman, announced that the Auxiliary will sponsor a card party at the Madison Hotel on February 7, 1934.

Mrs. Carl Surran asked the members to report to her any families who were in need, and emergency relief would be given them by her committee.

Mrs. Edwin H. Harvey, courtesy chairman, reported flowers sent to Mrs. Thomas Dunlap, who is in the hospital.

A social hour was enjoyed after the business meeting and refreshments were served.

There were 24 members present.

Bergen County

Mrs. Leroy W. Black, Reporter

The regular meeting of the Woman's Auxiliary to the Bergen County Medical Society was held at the Englewood Hospital November 14 with Mrs. Samuel Alexander, the President, in the chair. Two new members were present.

Miss Louise Zimmerman, District Supervisor of Midwives of the Bureau of Child Hygiene of the State Department of Health, spoke on "The Progressive Midwife". She showed how carefully midwives are supervised and instructed by the State, thereby making them safer in their practice.

A motion was carried to set aside a sum from the treasury as a "Philanthropic Fund", to be used in the relief of physicians' families in need. A committee was appointed to take care of this fund. There are many physicians suffering from the effects of this depression and it is felt our duty lies first with their families. The doctor's pride often prevents him from receiving aid and no one better understands his needs than his own profession.

Camden County

Mrs. Gordon West, Reporter

The Fall Meeting of the Woman's Auxiliary to the Camden County Medical Society was held at Lakeland, the Camden County Tuberculosis Sanitarium, on Thursday, October 5. Mrs. Martin Col-

lier, whose husband is the medical director of the institution, was our hostess.

After a short business meeting conducted by our President, Mrs. A. H. Lippincott, Mr. Ernest Eaton, the New Jersey State Secretary for the Tuberculosis League, told us about tuberculosis in our state and that during the depression the death rate has decreased.

Mr. Doyle Hinton, the Delaware State Secretary for the Tuberculosis League, gave us a very interesting talk on the origin of the Christmas seal. He also had a very valuable and interesting collection of the stamps from Denmark and the United States.

Mrs. Robert W. Tomlinson, our national President-Elect, was also one of our guests. She talked to us about the things they are doing in Delaware.

After a tour of the buildings of the institution, tea was served in Mrs. Collier's home. Everyone enjoyed a very delightful afternoon.

The Card Party which the Woman's Auxiliary to the Camden County Medical Society gave at the Walt Whitman Hotel on October 21 for the benefit of the Camden County Tuberculosis Association was a huge success. Mrs. Ernest Hummel, the General Chairman, was well pleased with the way people responded this year.

Attractive little plants of various kinds of ferns and begonias were the prizes, one for each table. Several young girls from the Junior Section of the Camden Woman's Club sold candy. A cake sale held in conjunction with the party netted a very profitable sum also.

Those assisting Mrs. Hummel, besides the General Hospitality Committee, were Mrs. Thomas McConaghy, tickets; Mrs. Joel Fithian, cakes; Mrs. Joseph Roberts, prizes; and Mrs. Reba Bushey, candy.

Essex County

Mrs. H. A. Schachter, Reporter

The regular meeting of the Woman's Auxiliary to the Essex County Medical Society was held in the Academy of Medicine, Newark, on Monday, October 23, at 2.30 p. m.

Dr. L. A. Wilkes, Executive Secretary of the State Society, was guest speaker, and gave an interesting talk on "An Outline of Constructive Activities for Auxiliary Members".

Mrs. Fred G. Shaul gave a résumé of the Fall Conference of the State Federation of Women's Clubs. This was followed by a social hour.

A Scholarship Fund card party held at the Elks' Club Wednesday afternoon, November 15 at 2 p. m. was quite successful. Mrs. R. Hunter Scott, Chairman, was ably assisted by Mrs. G. A. Scheller, Mrs. Charles Rathgeber, Mrs. Charles Zehnder, Mrs. William Ferguson, Mrs. F. H. Baldwin and Mrs. W. D. Miningham.

Gloucester County

Reported by Mrs. Henry B. Diverty

October Meeting

The Woman's Auxiliary to the Gloucester County Medical Society met at the Hotel Pitman, the President, Mrs. E. I. Downs, in the chair. The members present were Mrs. S. Ashcraft, Mullica Hill; Mrs. R. K. Hollinshed, Westville; Mrs. F. G. Wandell, Clayton; Mrs. W. W. Pedrick, Sr., Glassboro; Mrs. W. W. Pedrick, Glassboro; Mrs. C. A. Bowersox, Woodbury; Mrs. Paul M. Pegau, Woodbury; Mrs. David Brewer, Woodbury; Mrs. E. I. Downs, Woodbury; Mrs. H. B. Diverty, Woodbury; Mrs. Knight, Pitman; Mrs. Sooy, Pitman; Mrs. T. M. Gairdner, Gibbstown; Mrs. Livengood, Swedesboro.

After the business meeting a social hour followed, joining the doctors in a "midnight feast" at the close of their business meeting. September 11 an executive meeting was held at the home of Mrs. J. H. Underwood, where a program was arranged for the year as follows:

Thursday, September 28, luncheon, 1 p. m. Committee, Mrs. C. I. Ulmer, Mrs. I. W. Knight, Mrs. C. T. Sooy.

Tuesday, October 31, card party, 2 p. m. Committee, Mrs. F. G. Sherman, Mrs. D. Brewer, Mrs. C. A. Bowersox, Mrs. P. M. Pegau.

Thursday, November 16, business meeting, 9 p. m. Social Committee, Mrs. I. J. Stewart, Mrs. B. A. Livengood, Mrs. W. E. Crain.

Tuesday, December 19, Christmas party, 2 p. m. Committee, Mrs. D. Brewer, Mrs. H. B. Diverty, Mrs. R. K. Hollinshed, Mrs. J. H. Underwood, Mrs. Laura Stout.

Thursday, January 18, business meeting, 9 p. m, Social Committee, Mrs. W. W. Pedrick, Mrs. F. G. Wandell, Mrs. I. W. Knight.

Thursday, February 22, Colonial tea, 2 p. m. Committee, Mrs. P. M. Pegau, Mrs. W. Brewer, Mrs. C. D. Pedrick, Mrs. W. E. Crain.

Thursday, March 15, business meeting, 9 p. m. Social Committee, Mrs. W. Stout, Mrs. D. B. Weems, Mrs. H. B. Diverty.

Tuesday, April 24, Spring meeting, 2 p. m. Speaker to be announced later. Committee, Mrs. C. I. Ulmer, Mrs. R. K. Hollinshed, Mrs. T. M. Gairdner, Mrs. A. B. Black.

Tuesday, May 15, annual meeting, 1 p. m. Luncheon and May party. Committee, Mrs. D. Brewer, Mrs. F. G. Sherman, Mrs. R. L. Moore.

November Meeting

The Woman's Auxiliary to the Gloucester County Medical Society met at the Hotel Pitman November 15. The President being absent, the Vice-President, Mrs. Fuller G. Sherman, took the chair.

After the businses meeting, the Social Committee, Mrs. W. E. Crain, Mrs. B. A. Livengood and Mrs. Steward, took charge. After adjournment of the medical meeting, the ladies were invited to join the doctors in the dining room, where a fine collation was served. Everyone enjoyed a very delightful evening.

A card party was held Tuesday, October 31, at the home of Mrs. J. Harris Underwood. About 60 women participated. The members of the committee for the afternoon were Mrs. Fuller G. Sherman, Mrs. David Brewer, Mrs. C. A. Bowersox and Mrs. Paul M. Pegau.

Hudson County

The regular monthly meeting of the Woman's Auxiliary to the Hudson County Medical Society was held at the Y. W. C. A., Fairmount Avenue, Jersey City, on the afternoon of Monday, October 2, at 2 o'clock.

It was the opening meeting of the season, and was called to order by the outgoing President, Mrs. George M. Culver.

Mrs. Culver greeted the members and welcomed them, saying that she hoped that they had come back from their long vacation with renewed

strength for the winter's work. She reminded them that the Auxiliary is starting its seventh year. She said that Mrs. Freile and Mrs. Nevin had carried it safely through its infancy, and that she herself had taken it at the creeping stage; but that due to the depression and the uncertain times, it had been handicapped in learning to walk. Now, however, it is getting to be a big child and must learn to stand squarely on its feet.

She bespoke for her successor, Mrs. Frank Nicholson, the same earnest coöperation and loyal support that they had always been so ready and willing to give the former leaders, and hoped through her efficient leadership they would go on to bigger and better things.

Handing the gavel to Mrs. Nicholson, she said, "Madam President, I hand you the gavel and with it this thought—

'Yesterday is already a dream and
Tomorrow is only a vision,
But today well spent
Will make every yesterday a dream of happiness
And every tomorrow a vision of hope.'

I wish you success."

Mrs. Nicholson accepted the gavel and thanked the members for the honor bestowed upon her.

The minutes of the previous meeting were then read and approved. Following this, the yearly report of the Treasurer and that of the Corresponding Secretary were read and approved.

The new business consisted of naming the Chairmen of committees: Chairman of Widows' and Orphans' Relief Fund, Mrs. B. T. D. Schwarz; Chairman of Program, Mrs. Arthur Largay; Mrs. Warren Duckett and Mrs. Joseph Murray. Chairman of Entertainment, Mrs. Charles Kelley; Chairman of Press and Publicity, Mrs. George M. Culver.

An innovation is to be the naming of a hostess for each meeting, she to choose a group of members to help serve.

It was also voted that each member should contribute $1, during the month in which her birthday occurred, to be used for the refreshments during the winter.

It was voted to have a Christmas Party, talent to be presented from the Auxiliary. Mrs. John Nevin will give a book-review. On that day there will also be a Membership Tea—to which each member is asked to bring a new member, thereby doubling our membership.

In January we will have our annual card party to swell our funds for charity.

The speaker for the afternoon was Dr. Frederic J. Quigley, President, New Jersey State Medical Society. He gave us an interesting talk and outlined some of the work to be done by the State Society during the coming year. He stressed an objective for the Auxiliary work and suggested a Speakers' Bureau in each county society (the women to be the speakers) to give health talks wherever and whenever necessary.

He also urged a campaign against false advertising, both in magazines and over the radio.

After his talk, he afforded the members an opportunity to ask questions, and an interesting discussion took place.

The meeting adjourned, and Mrs. James Murphy, as Chairman of hostesses, poured tea, and a group whom she selected helped serve the refreshments.

Passaic County

Reported by Mrs. Edward Leonard

The Woman's Auxiliary to the Passaic County Medical Society held its first meeting at the Elmwood Club October 17. Guests were Mrs. H. Roy Van Ness, one of the Vice-Presidents of the national organization; Mrs. Theodore Teimer, State Chairman of Widows' and Orphnas' Fund; and Mrs. F. J. McCaulay, President of the Essex County Medical Auxiliary.

Following luncheon and a short business meeting, Mrs. William A. Dwyer, the President, welcomed the guests, who spoke briefly about their programs for the coming year.

Mrs. Teimer made an appeal in behalf of the Society for the Relief of Widows and Orphans of the Medical Men of New Jersey. She described the work done by the organization, and the qualifications for membership. She asked those present to coöperate with the Medical Society in its membership drive.

Mrs. O. R. Hagen gave a brief outline of the work of her committee for the coming year. The most important activities are diphtheria immunization and the examination of the pre-school child.

Announcement was made of an Advisory Board, consisting of Past-Presidents: Mrs. G. E. Tuers, Mrs. A. M. Schultz, Mrs. James Morrill, Mrs. William Neer and Mrs. Charles R. Russell.

The following is a list of committees:

Program: Mrs. C. E. Russell, Chairman; Mrs. R. J. McDonald, Mrs. James Morrill, Mrs. J. Birely.

Public Relations: Mrs. O. R. Hagen, Chairman; Mrs. T. Clay, Mrs. L. Cohen, Mrs. H. Gachman, Mrs. S. Levine, Mrs. L. Lomauro, Mrs. Burt Botbyl, Mrs. A. M. McBride, Mrs. J. Nye, Mrs. William Spickers, Mrs. A. Schulman, Mrs. P. Westerhoff, Mrs. H. Taber, Mrs. J. Thorne, Mrs. H. Briody, Mrs. J. Cremens, Mrs. C. Gordon and Mrs. A. MacGregor.

Social: Mrs. Burt Botbyl, Chairman; Mrs. J. Carr, Mrs. J. De Rosa, Mrs. L. De Yoe, Mrs. C. Flood, Mrs. R. J. McDonald, Mrs. C. Mitchell, Mrs. A. Pelusio, Mrs. G. Walton, Mrs. J. Birely.

Membership: Mrs. J. E. Phelps, Chairman; Mrs. William Spickers, Mrs. J. Lomauro.

Widows and Orphans: Mrs. E. J. Marsh.

Publicity: Mrs. E. F. Leonard.

Somerset County

Esther A. Levy, Reporter

A regular meeting of the Woman's Auxiliary to the Somerset County Medical Society was held at Bernard's Inn, Bernardsville, New Jersey, on October 29. This meeting preceded the annual meeting of the Medical Society. There was a large attendance and 3 new members were enrolled.

The President, Mrs. Ely, outlined a program of activity for the ensuing year which impressed the Auxiliary so much that it was agreed to accept this outline in its entirety. Among other things, it was decided (1) to stress the importance of membership in the Society for the Relief of Widows and Orphans of Physicians, and (2) to obtain subscriptions to Hygeia.

After adjournment, the ladies joined the men at dinner, during which Dr. Johnson, of New Brunswick, spoke to those assembled on public health work. Mr. Harry C. White, of Bound Brook, followed with some reminiscences of his associations with Dr. Steinmetz and Thomas A. Edison. Both talks were well received and brought a most delightful afternoon to a fitting close.

County Society Reports

ATLANTIC COUNTY

L. M. Walker, M.D., Reporter

October Meeting

The regular monthly meeting of the Atlantic County Medical Society was held at the Hotel Chalfonte on October 13, with 63 members present. Dr. C. H. de T. Shivers presided.

Dr. E. H. Harvey was appointed Chairman of the Public Health Committee, taking the place of the late Dr. W. Blair Stewart

An Advisory Committee was appointed as follows: Dr. J. S. Irvin, Chairman; Drs. C. M. Fish, D. W. Scanlon, I. Shenfeld, A. M. Smith and J. L. Roark. Dr. Irvin requested all physicians in the Society who wished to do work for the State Relief to communicate with him by letter.

Dr. Harvey wished to know who was taken care of by this fund; only those receiving state aid or any really indigent family?

Dr. Quinn stated that since a certain fee was allowed for confinement cases, surely a large proportion of multiparas now hospitalized as free patients could be delivered by physicians at home for which this Relief Fund would pay, thus relieving the hospital burden.

Death has taken the following members from the Society during the past few months: Dr. W. Blair Stewart, Dr. W. J. Doherty, Dr. A. D. Cuskaden and Dr. J. J. Richardson.

Dr. Harvey read a Memoriam to the late Dr. W B. Stewart in which tribute was paid to the fine and endearing qualities possessed by him. Dr. Harvey very fittingly summarized the life of Dr. Stewart in the following manner:

"Both heredity and environment gave to him that loftiness of purpose and character, best shown and best known by the Great Master and the Great Physician when it was said of Him—He went about doing good."

The application for membership of Dr. Leo Kahn was referred to the Board of Censors for action. The transfer of membership of Dr. E. T. Wright from Middlesex County was accepted.

A letter from the Treasuer of the State Society was read stating that the 1934 assessment was $13 per capita. This must be paid by January 27, 1934, in order that the name of the member shall be included in the listing for next year.

Dr. Irvin read a letter from the Venereal Disease Bureau stating that copies of the Bulletin could be subscribed for at the rate of 50 cents per year. This publication contains abstracts of all recent important papers covering this subject.

Dr. A. G. Ireland, Chairman of the Public Health Committee of the State Society, addressed the meeting, urging the members to do all in their power to promote public health work properly. He said that too much of this work is being done now by commercial clinics, schools, hospital dispensaries and social service and welfare societies.

Dr. Ireland emphasized the need for getting people into the habit of going to the doctor for vaccinations, immunizations and such other preventive measures as are now being done in so many cities by health departments and other agencies.

Dr. L. A. Wilkes, Executive Secretary of the State Society, also said a few words to the members regarding this work.

In the scientific program which followed, Dr. Ross V. Patterson, Dean, Jefferson Medical College, Philadelphia, presented a paper entitled "Coronary Thrombosis with Special Reference to Its Differentiation from Abdominal Surgical Conditions".

November Meeting

The regular monthly meeting of the Atlantic County Medical Society was held November 10 at the Hotel Chalfonte, Dr. C. H. de T. Shivers, President, in the chair. There were 55 members and guests present.

The minutes of the October meeting were read and accepted.

Dr. H. S. Davidson reported for the Board of Censors that the applications of Drs. J. W. Spear and Leo Kahn were acceptable and they were elected to membership in the Society.

Medical Service and Care in Atlantic County

Dr. E. H. Harvey, Chairman of the Public Health Committee, made the following report:

Your Health Committee met on October 31 with no absentees. They had the assistance and views of your President, Dr. Shivers, and of the Chairman of the Medical Advisory Committee, Dr. Irvin.

It was decided to invite the heads of any association, society, hospital, clinic, or other organization in the county having anything to do with medical service or practice, to meet with us.

This meeting was held on November 7 with the following in attendance: Dr. Samuel Salasin, Board of Health; Misses Hyde, Carroll and Taylor, of the Board of Health and Municipal Hospital; Miss Nichols, Visiting Nurses and Tuberculosis Association; Mrs. Flower, Baby Keep Well Clinic; Miss McGurran, Atlantic City Hospital; Mr. John Arleth, Arleth Hospital; Drs. Doughty and Steigerwald, Atlantic City Dental Association; Messrs. Cross and Holmes, Emergency Relief Committee; Dr. Guion, Asylum; Dr. Hudson, Tuberculosis Care; Dr. Scott, Free Clinic; Dr. Scanlon, Social Welfare Committee of the State Medical Society; Dr. Conaway, Trustee, State Medical Society; Dr. Axilrod, Small Fee Clinic; Mr. Rees Roberts, Atlantic City; Dr. Shivers, President, Atlantic County Medical Society; Drs. Barbash and Darnall, of the Atlantic County Medical Society; Dr. Irvin, Medical Advisory Committee, Atlantic County Medical Society; Mr. Bates; and your committee of 3. This made a total of 27.

There was general discussion of the many phases of medical service and care in Atlantic County. This resulted in much valuable information for your committee as well as an abundance of food for thought.

The objects of the meeting, stated so as to coincide with the views of the State Medical Society, were as follows:

(1) To provide adequate medical care to every one in the community.

(2) An assumption of leadership on the part of the Atlantic County Medical Society tending toward the complete coöperation of physicians and all health and welfare organizations.

(3) An honest and tactful effort to place as many as possible of the physicians, nurses, dentists, druggists, welfare workers and hospitals on a pay or salary basis.

It was moved, seconded and unanimously carried that the above objects be recommended to the County Society for adoption.

It was moved, seconded and carried that we have more of these large group meetings for further so-called "round table" discussion of health matters, medical practice and medical service. These meetings are to be held subject to the call of the chair.

Your Committee, therefore, recommends:

(1) That there be more and better social service and social investigation by the County Medical Society and its members, where possible.

(2) That better business methods be followed by

the members of the Society. It is not charity to give medical advice, service, and care to those who are able to pay for these things. It belittles the profession, and works harm to our fellow practitioners. It is self-negation and self-degradation.

(3) That earnest efforts be made by the Society and its individual members to show both physicians and laymen their part in matters of mutual interest. The physician has been derelict in allowing the layman to administer medical affairs. There are many abuses besetting the medical profession, some the result of the physician's own action, inertia, carelessness, or self-effacement. The layman must be reached by radio talks, parent-teachers' gatherings, health campaigns, health weeks, and talks before civic clubs and the like.

Two members of your Health Committee have already spoken to Parent-Teachers' Meetings.

The recommendations of the Health Committee were adopted by the Society.

Dr. J. S. Irvin, reporting for the Medical Advisory Committee, stated that the Committee is to meet with Col. Bigley, of the Emergency Relief Committee, to discuss a proposal to make the doctor state his diagnosis on the form which constitutes his bill for services. Dr. Irvin did not think this should be permitted, as it would interfere with the personal relationship between the doctor and his patient.

Dr. W. E. Darnall, of the Library Committee, reported that several new books had been added to the Library in the last few months.

The President appointed the following Nominating Committee for the election of officers at the December meeting: Dr. E. H. Harvey, Chairman; Dr. W. B. Stewart and Dr. W. E. Darnall.

The application for membership of Dr. Samuel Halpern was referred to the Board of Censors.

The bill of $20 for dues in the Chamber of Commerce for 1933 and 1934 was received by the Secretary and voted to be paid by the Society.

The Scientific Program was as follows:

(1) "The Medical Management of Thyroid Disease", Dr. J. T. Beardwood, Associate Professor of Medicine, Post-Graduate School, University of Pennsylvania. Discussion by Harold S. Davidson.

(2) "The Surgical Management of Thyroid Disease", Dr. F. A. Bothe, Associate Professor of Surgery, Post-Graduate School, University of Pennsylvania. Discussion by Dr. V. E. Johnson.

Dr. L. E. Myatt, of Bridgeton, discussed briefly both papers.

CAMDEN COUNTY

Vincent Del Duca, M.D., Reporter

The regular meeting of the Camden County Medical Society was held in the Camden City Dispensary Building, November 7. Dr. T. B. Lee presided.

The following were elected to active membership: From Camden, Drs. William T. Read, Jr., Banks S. Baker, David L. Andrus, Arthur G. Pratt, Joseph M. Stein, Grant O. Favorite; from Lakeland, Thomas H. Glade.

Dr. George Griffith, Cardiologist of the Presbyterian Hospital, Philadelphia, Pa., read a paper on "The Cardiac Arhythmias and the Significance of Venous Pressure". The cardiac arhythmias were illustrated with animated moving pictures of heart action, synchronized with electrocardiographic tracings. He was assisted in his demonstration of the reading of venous pressure by Drs. J. R. Ketchall and C. T. Chamberlain. Discussion was opened by Dr. T. K. Lewis, followed by Drs. Ralph Hollinshed, T. M. Kain and Hyman J. Goldstein.

At the invitation of the President, Mr. E. Blankstcen, representing the National Casualty Company of Detroit, which offers a group policy of health insurance to the members of this Society, gave a brief description of the policy offered.

There were 86 doctors and guests present. Drs. Downs and Tracey, from Burlington County, and Drs. Diverty and Hollinshed, from Gloucester County, were among the guests.

CAPE MAY COUNTY

Eugene Way, Reporter

The fiftieth anniversary of the Cape May County Medical Society was observed at the annual meeting held at the Ocean City Golf Club, Somers Point, on Tuesday, November 14.

A paper was read by Dr. James H. Ingram, of Pekin, China, who 50 years ago practiced medicine in this country. He told of his experiences as a medical missionary in China. Dr. Ingram located at Green Creek after graduating from the University of Pennsylvania in 1883. After 2 years he removed to Holly Beach. In the Fall of 1887 he went to China as a medical missionary under the American Board. He is now on the retired list. Dr. Ingram paid a brief visit to this country 3 years ago.

Dr. Walter J. Lillie, of Temple University Hospital, gave an address on "The Mayo Clinic". Professor Lillie was a member of the clinic for 16 years and gave its history from the beginning to the present time. He described graphically the various lines of work and the results achieved by a staff of 130 specialists.

Other speakers were Dr. Lancelot Ely, Vice-President of the State Medical Society; Dr. J. Bennett Morrison, Secretary of the State Society; and Dr. Julius Way, county physician.

Guests present from surrounding counties were: Dr. Harry B. Diverty, Gloucester; Dr. William Carrington, Dr. Walter Stewart and Dr. Earl V. Johnson, Atlantic; Dr. Herbert Wilson, Dr. H. G. Miller and Dr. Samuel Bennett, Cumberland, and Miss Cellie McGurran, superintendent of the Atlantic City Hospital.

A feature of the meeting was a display of medical exhibits which are housed in the museum of the Cape May County Historical Society. Edward M. Post, custodian of the museum, was in charge of the exhibit.

An exhibit of surgical instruments used during the Revolutionary War period by Dr. John Dickinson was displayed. In the collection is a sword presented to Dr. Dickinson by General George Washington.

Dr. Warren D. Robbins, of Cape May, was elected President of the Society for 1934. He succeeds Dr. Allen Corson, of Ocean City. Other officers chosen were: Dr. John B. Townsend, Ocean City, Vice-President; Dr. Eugene Way, Sea Isle City, Secretary (reëlected for the twenty-sixth year); Dr. H. H. Tomlin, Wildwood, Treasurer; Dr. Clarence W. Way, Sea Isle City, member of the Nominating Committee of the State Medical Society; Dr. Herschel Pettit, Ocean City, Delegate for 3 years to the State Medical Society; Dr. Julius Way, Court House, Chairman of the Welfare Committee; and Dr. Oscar Ziegler, Wildwood, Censor.

GLOUCESTER COUNTY

Henry B. Diverty, M.D., Reporter

The 115th Annual Meeting of the Gloucester County Medical Society was held on November 16 at the Hotel Pitman.

Officers elected at the meeting were: President, B. A. Livengood, Swedesboro; Vice-President, E. R Ristine, Westville; Secretary and Treasurer, R. K. Hollinshed, Westville; Reporter, H. B. Diverty, Woodbury. Board of Censors: William Stout, Wenonah; H. L. Sinexon, Paulsboro; Don Weems, Wenonah. Delegates to the State Society: William Pedrick, Glassboro; William Brewer, Woodbury; R. K. Hollinshed, Westville. Nominating Committee for the State Society: R. K. Hollinshed, Westville; Alternate, C. I. Ulmer, Gibbstown. Board of Trustees of the County Society: William Brewer, Duncan Campbell, J. Harris Underwood, all of Woodbury.

Reports were presented by: Dr. Hollinshed, Treasurer; Dr. I. W. Knight, Chairman of the Public Health Committee, and by other committees.

Wadsworth Creese, director of relief for Gloucester County, gave an interesting address before the society, presenting a résumé of the work that has been accomplished and the plans of the department for the coming winter.

Announcement was made that a meeting would be held by secretaries of the Cape May, Cumberland, Salem, Atlantic and Glouecster County Societies, comprising the Fifth District of the State Medical Society, at Atlantic City on November 21. The purpose of the meeting is to discuss the Emergency Relief Plan.

A talk on group insurance was given by James Blacksteen, a representative of one of the insurance companies.

Those present were: From Woodbury, Drs. Fuller G. Sherman, W E. Crain, Duncan Campbell, Dorothy Rogers and H. B. Diverty; from Williamstown, H. W. Wright and Horace M. Fooder; from Gibbstown, C. I. Ulmer; from Glassboro, Charles Pedrick and William Pedrick; from Swedesboro, B. A. Livengood; from Pitman, W. J. Burkett, I. W. Knight; from Westville, R. K. Hollinshed, E. R. Ristine; from Mantua, Louis Ruttenberg.

ESSEX COUNTY

Earl Le Roy Wood, Reporter

Dr. Edward W. Sprague presided over his first meeting as President of the Essex County Medical Society, Thursday evening, November 9, at the Academy of Medicine, Newark.

Remarks by the President

Dr. Sprague outlined briefly his policies, which are, in effect: (1) the loyal support of the State Society administration with protection, and (2) improvement of the economic welfare of the local physicans.

Continuing, Dr. Sprague said that it is doubtful whether at any previous time there has been a greater number of physicians suddenly impoverished; men who for years have been successfully earning their livelihood in the practice of medicine, now find their income vanished and are unable to maintain their former or any standard of living. The medical profession faces a crisis. It will be met in several ways, all of which deserve the attention and support of every physician.

(1) A relief fund has been created to aid members in distress. One thousand dollars ($1000) was transferred from the treasury to this fund, and a special assessment of $1 was levied on each member for the relief fund. *It is urged that each member send this additional dollar when he sends his $15 annual dues. This will avoid the cost of collecting this small assessment separately.*

(2) Means are being devised to remove from the doctor's shoulders, the tremendous burden of free medical care for the indigent sick. Funds will be provided by the State Emergency Relief Administration to pay physicians for this work at the rate of $2 per house call, $1 per office visit and a $25 obstetric fee. This subject will be treated in detail later in a report of a special meeting held for that purpose.

(3) The Committee on Economics and Public Relations, Wells P. Eagleton, General Chairman, will study and formulate long and short range policies to protect the physician's business and restore to him the practice that has escaped from his office and has been usurped by various other agencies. An outline of the structure and purpose of this committee follows. It is hoped that every physician will assist by active effort or by offering suggestions and ideas.

The Section on Economics

The Problems of the Section on Economics (James H. Lowrey, Chairman; F. C. Weber, Secretary) were taken up next.

These problems for study are:

(1) Pay to physicians for care of indigent patients. Already the State is paying for house calls and maternities. The question of clinic and hospital pay to the physicians must be discussed. This subject is of paramount importance and far reaching in consequence.

(2) X-ray and diagnostic or technical laboratories not sponsored by physicians.

(3) The set-up and operation of a permanent fund for relief of physicians in financial distress.

(4) Physicians' salaries in Essex County public positions: urging elevation wherever advisable, especially those in the lower brackets.

(5) The occulist; suggesting practical means by which he may recapture refraction work from business organizations.

(6) Medical lien law to cover physicians.

(7) Compensation Laws to be changed so that patient may have choice of physician.

(8) Medico-legal board of reference in court.

(9) Relation of physicians and other persons employed by insurance companies to other physicians. (Case lifting.) This Society is on record as opposed to case lifting. The hospitals should take an active part in developing a rule to prevent members of the staff who represent an insurance company, from taking over a case that previously had been under the care of one of the other members of the staff. This also applies to courtesy members of the hospital.

(10) Business procedures in the practice of medicine.

(11) The problem created by the great influx of foreign graduates in New Jersey.

(12) Contract practices in Essex County; what is an ethical contract?

(13) To take over the work of the Physicians' Business Bureau: (a) Question of finance plans; (b) question of collection agency.

(14) This Committee to be a fact finding committee for the study of the complaints of physicians as to the inroads of their work by institutions or business.

The Hospital Section

The problems of the Hospital Section (William H. Areson, Chairman; E. A. Flynn, Secretary) were then considered:

(1) The Hospital Section is composed of the Chief Executive Medical Officers in each hospital. An exchange of ideas may be beneficial. All mat-

ters of mutual interest pertaining to hospitals in Essex County should be brought before this Section for consideration and study.

(2) To answer the question—are the people of Essex County provided with adequate hospital and medical care, no matter what their financial status may be?

(3) To study the problem of efficient Social Service organizations in each hospital. (The State Society recommends that physicians' wives do this work. This is debatable.)

(4) To survey the problems of physicians in hospitals and clinics: (a) Study of clinic charges; (b) study of "flat rate" in hospitals for maternities and other conditions. This breaks up the physician-patient relationship and should be modified so that the physician may care for the patient.

(5) To study the question of uniform clinic admission in all hospitals: The so-called "Rochester Plan"—i. e., (a) first ask all patients applying for treatment whether they have a family physician or were ever under the care of one; (b) if so, to return with a letter of admission; (c) if an emergency—telephone, and, if no reply, admit and request physician for approval; (d) if there is no family physician, then refer to 3 of the staff for choice. (A. M. A. July 22, 1933.)

The Public Health Section

The following problems of the Public Health Section (Edgar A. Ill, Chairman) are to be taken up:

(1) General review and discussion of the State Medical Society Public Health Committee Plan. Essex County problems are peculiar to Essex County Medical Society. The State Committee suggests the "Monmouth County Plan". Are not most of the problems of dentists, nurses, druggists and various other organizations irrelevant to our problems?

(2) The development of a campaign in the Society to urge the public to have all vaccinations, diphtheria inoculations and routine examinations done in pre-school years. In that way the physician will be paid for his work, the physician-patient relationship preserved and the need for school clinics diminished. This problem is most important.

(3) To state our beliefs that physicians should occupy public health positions.

(4) Study of the "Detroit Plan", the ultimate object of which is to have the family physician take care of his patient in health as well as disease. The physician should lead the public in health prevention rather than have his patient depend upon public agencies and clinics. This is in strong opposition to the paternalistic tendency of the government to assume the burden which people should accept as their own.

(5) Periodic health examination.

(6) Diphtheria prevention.

(7) Adequate representation on the Hospital Council of Essex County.

(8) Questions pertaining to health and hospital insurance plans, so that a definite policy may be stated.

(9) Study and report on the question of revocation of medical licenses on recommendation of the County Medical Society.

(10) Report on question of medical representation on hospital boards.

(11) Study the question of medical testimony, especially in malpractice suits, as to the truth and ethical nature of the testimony.

(12) To assist in the education of the citizens of Essex County to a sense of their own responsibility in the care of indigent sick; to make them realize that the burden of free medical care is not the physician's problem alone. This program of education to be carried out in coöperation with the Public Press Committee.

The Society voted to become an incorporated body. Legal advice was quoted to show that the action of incorporating had every advantage and no disadvantages. Many county medical societies in our country are incorporated.

Dr. Frederic J. Quigley, President of the Medical Society of New Jersey, addressed the meeting, outlining his policies for the State Society. His message was similar to the one published in the November issue of the Journal. Dr. Francis R. Haussling, Second Vice-President of the State Society, in his discussion, expressed perfect accord with the views expressed by Dr. Quigley.

Dr. Alfred E. Shipley, new Editor of the Journal, was introduced, and briefly outlined the service of a State Society Journal as he understood it.

Dr. Le Roy A. Wilkes, the new Executive Secretary of the State Society, was introduced, and made a few brief remarks.

Drs. Frank Devilin and David A. Kraker participated in the general discussion sympathetically.

The following were elected regular members: Drs. Millard B. Erwin, Joseph H. Muller, Francis J. Shockley and William H. Washington. For Associate Membership: Drs. C. Abott Beling, F. J. De Fino, Emanuel Liccese and Herman H. Tillis.

(Since the November meeting of the Essex County Medical Society, a special report of the activities of some of its committees has been received, as follows:)

The sections of the Economics and Public Relations Committee have promptly started to function, realizing the importance and vital nature of their work. Each section has met, and begun to attack its problems. The general procedure has been to assign specific problems to sub-committees.

The Chairmen of sub-committees of the Hospital Section are Drs. Condon, Hawkes and Vannatta.

The Public Health Section, under the leadership of Dr. Edgar A. Ill, is considering the following recommendations:

(1) That the Public Health Committee shall act in an advisory capacity to all bodies carrying on public health activities, and that it request the executive heads of such departments not to institute new activities without the advice and approbation of this committee of the Essex County Medical Society.

(2) That these Public Health bodies be urged to make their work educational; to cease all forms of the practice of medicine; and, instead, to educate the public to consult their own doctors, from whom personal interest and the most competent treatment can be received.

(3) That the Newark City Dispensary Public Health Clinics be moved to the City Hospital and be placed under the control of the City Hospital Staff, which has made the City Hospital such an excellent institution.

(4) That doctors who will set aside an hour each week, register for immunization and vaccination work, (as in the Detroit Plan) at $1 per inoculation.

(5) That legislation be enacted to make it compulsory for all public health executives to be medical men. In other words, medical men for medical jobs.

Newark Meeting

Discussion of Medical Relief Plan under the Emergency Relief Administration

In an effort to expedite matters of emergency medical relief, a meeting called by First District Councilor Christopher C. Beling was held in the Academy of Medicine, Newark, Thursday afternoon, November 9. Representatives of the medical profession and of the relief administrators were present.

The questions considered were, *"Why is the relief plan not functioning in Essex and Union?"* and *"What are the problems for the doctors to solve?"*

Drs. Frederic J. Quigley, Le Roy A. Wilkes, S. T. Snedecor and C. H. Schlichter represented the physicians of the State; and Colonel Joseph H. Bigley and Dr. Tucker, of Princeton, medical advisor to Mr. John Colt, represented the State Emergency Relief Administration. The County Medical Committees and Relief Administrators also were present.

The fact that Newark has had 3 different administrators in 6 months has complicated the local problem. Some County Administrators have not felt that they had full authority to proceed; others have awaited official interpretation of the plan. Assurance was given by Colonel Bigley that the plan, as agreed upon, would begin to function very shortly.

Among the problems for the physicians to solve with the inauguration of the plan are, (a) to secure the best medical care of the sick with free choice of physician by the sick; and (b) prompt and proper payment of the physician with a minimum of red tape for all concerned. The Relief Medical Advisory Committee should be strong and active, assuming authority for the physicians on the approval list. These representatives of the County Society will have authority to remove from the list the name of any physician who attempts exploitation, "chiseling", or improper, dishonest, or unethical practices. The medical profession must not be brought into disrepute by one individual or even a small group, nor should any physician attempt to secure more than his fair share of the fees. Bills should comply accurately with the plan. Copies of the plan should be studied and will be available at the Academy of Medicine. (See message of Dr. Snedecor in the Journal, August issue, pages 591-592.)

More than casual attention should be given to the Emergency Relief Plan which will provide for the payment to doctors for medical care of the indigent sick. This type of work has been, for a long time, a heavy burden on the doctor and financially, to him, a total loss. This proposed remuneration may possibly become the means of existence of a goodly number of our members. Many of our physicians find themselves unable to carry on unless they receive financial compensation from some source; all of their resources have been exhausted in giving service for which they have not been paid. They have given themselves and all that they had, in accordance with the traditions of their profession.

The various ramifications of the Relief Plan should receive serious consideration by all physicians. About ⅓ of the Essex County Society membership expressed a desire to coöperate with the Emergency Relief Administration. They are impatiently awaiting it to begin to function.

The Academy of Medicine of Northern New Jersey

Adrian Ralph Kristeller, D.D.S., Secretary

October Meeting

The Academy of Medicine of Northern New Jersey started its twenty-third season with Dr. Frank H. Lahey, of Boston, as its guest at the meeting held on October 19.

Dr. Lahey's topic, "The Management of Gastric or Duodenal Ulcer", was most interesting to a capacity audience.

It was one of the largest gatherings the Academy has had in some time.

The guest for the next stated meeting will be Benjamin Kramer, M.D., Pediatrician-in-Chief of the Brooklyn Jewish Hospital. His talk will be on "The Value of Antirachitic Milk as Determined by Clinical Tests".

Section of Medicine and Pediatrics

Benjamin Saslow, M.D., Secretary

November Meeting

The 167th meeting of the Section of Medicine and Pediatrics, held at the Academy of Medicine on November 16, was called to order by Dr. Bingham, President of the Academy. The minutes of the last meeting were read by Dr. Kristeller. An amendment was added to the Constitution whereby members of the Academy of Medicine who have been in good standing for 20 years may continue without further payment of dues upon application to the Academy.

The Value of Antirachitic Milk as Determined by Clinical Tests

The Chairman of the Section, Dr. Polevski, introduced the speaker of the evening, Dr. Benjamin Kramer, of Brooklyn, N. Y. His subject was "The Value of Antirachitic Milk as Determined by Clinical Tests".

Dr. Kramer opened his talk with a succinct history of the treatment of rickets, and the discovery and standardization of vitamin D in cod-liver oil, viosterol and vitamin D milk.

In 1925, Dr. Kramer discovered that cows' milk activated with vitamin D by irradiation with the mercury vapor quartz lamp, for 1 hour, could cure rickets in about 8 weeks. At that time, no standard had been established for the quantitative vitamin content of irradiated substances. Since then, however, Steenbock has established the vitamin D unit as a certain measured amount of vitamin D, sufficient to bring about a pre-determined amount of healing in bones of rachitic rats. Subsequently, Dr. Kramer modified his original method by exposing thin layers of fluid milk to the flaming carbon arc lamp for a period of 16 seconds; such milk has an average potency of 55 Steenbock units per liter. Dr. Kramer felt that, although vitamin D milk contains less vitamins than either viosterol or cod-liver oil, it is equally effective as a antirachitic agent because of its intimate contact and possible reaction with the inorganic calcium and phosphorus contained in the milk.

Another type of vitamin D milk now available in the open market is the so-called "yeast milk"—milk from cows that are fed irradiated yeast. One hundred thousand Steenbock vitamin units in yeast are added to the daily diet of these cows, and their milk acquires a potency of approximately 160 Steenbock units a liter. Irradiation of the cows

themselves does not increase the vitamin content of their milk.

In rickets, Dr. Kramer pointed out, there is a disturbance in the calcium and phosphorus balance; the excretion of both phosphorus and calcium increases in the acute stages, and decreases during convalescence and healing. Excretion of calcium is almost entirely through the large bowel. On the other hand, most of the phosphorus passes out through the kidneys. Howland and Kramer determined the inorganic phosphate of the serum of normal infants to average 5.4, and the average calcium content to be between 10-11 mg. per 100 c.c. of serum. In rickets, both these figures are decreased.

Although the incidence of rickets has decreased, Hess and Lewis, from a study among infants and children attending child health stations in New York City, have shown that ¾ of the Negro and nearly ½ of the white infants have definite clinical evidence of this disease. Gittleman and Kramer found that 20% of children attending pediatric clinics in Brooklyn carry some stigmata of rickets. This disease, Dr. Kramer emphasized, is more likely to occur when an increase of weight is rapid; most cases are seen in very young or premature infants. Conversely, if the child ceases to gain, the rachitic condition tends to heal.

The diagnosis of early rickets can only be made by roentgenological and chemical examinations. Clinical diagnosis of this condition in its early stages is notoriously inaccurate. The large wrists do not occur except in advanced rickets. Sweating of the head is unreliable, and most bowing of the legs in children is non-rachitic.

Rickets can be cured by vitamin D milk, viosterol, cod-liver oil, carbon ray and quartz mercury vapor lamps.

Dr. Kramer and his co-workers recently undertook a study of 2 strengths of vitamin D milk, one containing 55 and the other containing 40 Steenbock units per quart. They found that these milks contained much less vitamin D than cod-liver oil or viosterol, nevertheless they were just as efficacious, prophylactically and curatively.

The speaker showed a large number of roentgenograms demonstrating the healing effects of vitamin D milk upon the rachitic bones of children. These plates showed in a striking manner the increased condensation and fresh deposition of lime salts at the epiphyseal ends of the bones.

The whole subject of vitamin D, Dr. Kramer stated, is far from definite settlement. Some workers find the so-called vitamin D to be made up of a number of substances. Although cows' milk contains very much more vitamin D than human milk, the latter appears to be far superior to cows' milk as an antirachitic agent.

The paper was discussed by Drs. Murray, Polevski, Rothstein, Heyman and Fein. In closing, Dr. Kramer made the following interesting points: (1) The serum calcium and serum phosphorus must reach normal figures before there is roentgenological evidence of healing; (2) boiling does not destroy the vitamin content of vitamin D milk; (3) all the bones do not heal synchronously during convalescence in rickets; and (4) if, in the course of rickets, the serum calcium drops very low, or an abundance of phosphates is given, tetany may supervene.

By a rising vote, Dr. Kramer was thanked for his lucid and excellent exposition. The meeting was closed by Dr. Polevski at 10.45 p. m.

Eye, Ear, Nose and Throat Section

A. Russell Sherman, M.D., Secretary

October Meeting

The first Fall meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, October 9, 1933. The meeting was called to order at 8.45 by Dr. Browne Morgan, the chairman.

A talk on contact glasses, illustrated with lantern slides, was given by Dr. Willis S. Knighton, of New York City. Dr. Knighton mentioned the several attempts to make a contact glass, the earliest having been over 100 years ago, but said that the first really practical one was perfected in 1918.

He described in detail the glasses in use today, also a procedure to be followed in fitting them to the patient's eye. In conclusion, he stated that contact glasses fill a very definite need which can be taken care of satisfactorily by nothing else at our disposal today, but advised against prescribing them for anyone who can be satisfactorily fitted with ordinary spectacles or eyeglasses.

The second paper of the evening was by Dr. Alfred Cowan, of Philadelphia, whose subject was "Standard Forms of Ophthalmic Lenses".

He referred first to the changes in shape from flat to meniscus and toric made necessary during the past 25 years by the general use of larger lenses, and deplored the false claims made by manufacturers for their patented forms.

Dr. Cowan showed how the oculist can, in the great majority of cases, select from the standard forms a lens in no way inferior to the patented product. He urged all those engaged in refraction, in fairness to themselves and to their patients, to become familiar with some of the general principles of lens grinding and with the standard types of lenses available today, so that they may intelligently select the best lenses for each patient and specify them in the prescription.

He then discussed some of the newer forms of bifocals, and explained why, in certain types of cases, difficulty is experienced with bifocal lenses.

Both Dr. Knighton's and Dr. Cowan's papers caused considerable discussion and favorable comment.

The meeting adjourned at 11:15 p. m.

Forty-five members and guests were present.

November Meeting

A clinical meeting of the Eye, Ear, Nose and Throat Section of the Academy of Medicine of Northern New Jersey was held Monday, November 13, at the Newark Eye and Ear Infirmary.

Patients showing the following conditions were presented by members of the staff:

(1) *Dr. Adelman*:

(a) Generalized ichthyosis, with ectropion of the lower lids.

(b) Sclerosing osteitis of the orbit following perforating injury of the eye.

(2) *Dr. Charles Barkhorn*:

Malignant epidermal carcinoma of the roof of the mouth.

(3) *Dr. Chattin*:

Contusion injury of the choroid and retina.

(4) *Dr. Russell Sherman*:

(a) Lenticonus posterior.
(b) Pemphigus of the conjunctiva.

(5) *Dr. Rogers*:

Abscess of the orbit following gunshot injury.

(6) *Dr. E. S. Sherman and Dr. Hurff*:

Patients after successful operations with diathermy for retinal detachment.

(7) *Dr. Rogers*:

Patient after a Guist operation followed by re-attachment of retina.

(8) *Dr. Peer*:

(a) Two patients—Plastic repair of a coloboma of the upper lid following excision of a carcinoma.
(b) Plastic repair of a cicatricial ectropion. Dr. Peer illustrated with lantern slides the operative procedure used in treating these patients.
(c) Bony defect in the skull, repaired with a dermal graft.

(9) *Dr. Hughes*:

History of a patient who had had a laryngectomy for carcinoma in December 1932. In September 1933, metastasis to the iris of one eye was noted, and the eye was enucleated. The patient died from general metastasis about 3 weeks after the removal of the eye. Dr. Hughes showed a section of the enucleated eye which confirmed the clinical diagnosis.

(10) *Dr. Cardwell*:

(a) Clinical course of a case of staphylococcus septicemia in an 8-year-old child. Bacteriophage had been used with good results.
(b) Mastoid for necrosis of ossicles.
(c) Radical mastoid for cholesteatoma.
(d) Cholesteatoma without history of discharge from car.
(e) Chronic petrous suppuration.
(f) Acute suppurative otitic meningitis.
(g) Compound fracture of frontal bone with laceration of dura and loss of cerebral tissue.
(h) Oesophageal diverticulum.
(i) Infected thyro-glossal duct cyst.
(j) Thyro-glossal duct fistula.

Following adjournment at 11 p. m., a collation was served. Sixty members and guests were present.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The meeting of the Hudson County Medical Society was called to order on November 8 by Dr. Louis A. Pyle, the retiring President.

After the Society completed unfinished business of the old administration, Dr. Pyle thanked the members of the committees who worked for him during the past year, and then he relinquished the gavel to the new President, Dr. Daniel Street.

Dr. Harry Perlberg, Secretary, read a letter from Dr. Snedecor, Councilor, Second District, stating that at the request of the President of the State Society, he was calling a Councilor District meeting to discuss the Emergency Relief Plan. Dr. Perlberg replied to Dr. Snedecor's letter, reminding him that at a special meeting of the Hudson County Medical Society, on May 12, this entire matter of the Emergency Relief Plan had been discussed, and action in the matter had not been approved. Dr. Snedecor then suggested that the Emergency Relief Plan be again referred to the Society with the request that a committee be appointed by its President to act as an observer at the District Meeting, on November 16. The proceedings of this meeting could thus be reported to the Society, which might result in further consideration of the matter.

Dr. Pyle moved that the President appoint such a committee as requested by Dr. Snedecor, to attend the District Councilor Meeting, and report back to the Society. This motion was seconded and carried.

Under new business, Dr. Maras made it clear to the Society that Dr. Miner did not request him to publish in the Bulletin an opinion concerning the report of the committee dealing with the problems of the Jersey City Medical Center. Dr. Miner was Chairman of this committee.

A resolution offered by Dr. Brennock was passed, in which the Society expressed its high appreciation of the services of Dr. Henry O. Reik, who resigned recently as Editor and Executive Secretary of the State Society.

Dr. Cosgrove moved the adoption of a rule for the coming year, limiting any one individual to 5 minutes on the floor for discussion on committee reports and other matters. After discussion, Dr. Maurice Shapiro moved the matter be referred to the Committee on Constitution and By-Laws. This was carried.

Dr. Street announced that the Program Committee had asked Christ Hospital to take charge of the scientific session at the next meeting. It is the purpose of the Program Committee to request a number of the hospitals in the county to be responsible for the scientific part of the monthly meetings this year.

MIDDLESEX COUNTY

Medical Section of Rutgers Club

John H. Rowland, M.D., Secretary

October Meeting

The first regular meeting for the Fall season of the Medical Section of the Rutgers Club was held on Wednesday evening, October 25, at the Forsgate Farms Country Club. The members, with friends and guests, were the guests of Mr. E. D. Mitchell, Superintendent of Forsgate Farms. A very delightful dinner was served.

The scientific part of the program was presented by Dr. James Waddel, of E. I. Du Pont Co., Parlin; Dr. Archie Black, of E. R. Squibb & Son, New Brunswick; and Dr. Walter Russell, of the New Jersey Agricultural Station, New Brunswick. Each speaker talked for about 30 minutes on various phases of the subject, which was: "Vitamins A and D; Their Clinical Status at the Present Time, and Their Preparation for Administering". The paper was discussed by Dr. Gutmann, Dr. Brown and Dr. Johnson.

There were 28 members and guests present. Dr.

Howley presided. The meeting adjourned at 11 o'clock.

November Meeting

The regular meeting of the Medical Section of the Rutgers Club was held at the Alumni House, Queens Campus, Rutgers University, on Friday, November 24. Dr. Howley, Chairman of the Section, presided.

The speaker of the evening was Dr. Leonard Rowntree, Director of the Medical Research Institute of Philadelphia, and formerly Director of the Medical Department at the Mayo Clinic. His subject was "Endocrine Glands". The talk was most interesting and instructive.

The paper was discussed by Dr. Gutmann, Dr. Berkow and Dr. Morrell.

After the meeting, refreshments were provided by the Entertainment Committee, on which were Dr. Rothschild, Dr. Rowland, Dr. Scott, Dr. Sherman, Dr. Smith and Dr. Sullivan.

MONMOUTH COUNTY

Robert A. MacKenzie, M.D., Reporter

The October Meeting of the Monmouth County Medical Society was held Wednesday evening, October 25, at the Fitkin Memorial Hospital, Neptune. An unusually large attendance was present, as this was the first meeting of the Fall, with a program of interest to everyone.

After a short business session, the President of the Society, Dr. Watkins, turned the meeting over to Dr. W. F. Jamison, of Asbury Park, Dermatologist to the Fitkin Memorial Hospital and the Monmouth Memorial Hospital of Long Branch.

Syphilis—Importance of Early Diagnosis and Treatment

Dr. Jamison introduced the guest speaker, Dr. Isadore Rosen, Professor of Dermatology and Syphilology at the New York Post-Graduate Medical School of Columbia University. Dr. Rosen outlined his subject, "Syphilis—Importance of Early Diagnosis and Treatment", made pertinent comments, with the projection of a large number of slides illustrating skin manifestations of the disease. Following this demonstration, Dr. Rosen answered questions until a late hour, and succeeded in assisting members of the Society who have problems bearing upon the management of this all-important disease.

In opening his presentation, Dr. Rosen emphasized the newer consideration of syphilis as a constitutional disease in contrast with the old belief that several weeks elapse between the appearance of the initial lesion and the invasion of the blood stream by spirochete. He stated that now it is definitely established that the invasion takes place 10 to 20 days before the chancre appears, organisms having been recovered from both blood stream and spinal fluid during this period. Ideally, syphilis should be treated as soon as the primary lesion is recognized, before the Wassermann reaction shows positive. Clinical diagnosis of the initial sore assumes great importance, therefore, and it is well to suspect cases where the appearance has been altered by treatment with antiseptic dressings or caustics. The next most favorable situation from the standpoint of success in treatment, is where the patient presents himself with a primary lesion of such duration that the Wassermann test shows a positive reaction. Even where secondary symptoms exist, following upon or coincident with the primary lesion, the outlook for complete arrest of the disease is good provided therapy is thorough. In all 3 of the conditions mentioned, treatment must be vigorous with emphasis upon regularity and persistence. Dr. Rosen suggested 3 courses of treatment during the first year, each course to consist of 10 injections of salvarsan or neo-salvarsan given one a week, followed by 15 biweekly intramuscular injections of mercury or bismuth. There may be a rest period of 4 weeks between the courses, but longer intervals detract from the certainty of good results. During the second year, 2 or 3 similar courses of treatment are desirable, and 2 courses certainly should be given during each of the 2 succeeding years. Dr Rosen stressed the impossibility of standardized treatment since every case must be treated individually. He stated that "the treatment of syphilis does not consist merely in the injection of specific remedies". He mentioned the importance of questioning the patient and making a careful examination before each intravenous injection. Thus it may be possible to detect signs of intolerance and avoid serious consequences. He described the care necessary in preparing arsenicals particularly, and urged that the initial dose be small and well diluted. Slow administration, preferably by gravity, helps to avoid shock, and establishes the patient's toleration for the drug. To illustrate the importance of persistent treatment, the speaker described from his wide personal experience, cases of syphilis of the nervous system and other tertiary lesions developing in malignant form where treatment had been inadequate. He expressed his belief that insufficient treatment is worse than no treatment at all.

Dr. Rosen emphasized for special consideration latent syphilis, cardiovascular syphilis, cerebrospinal syphilis and congenital heredosyphilis, all tertiary forms. He mentioned the importance of selective management in each of the above subdivisions of this protean disease, but the lack of time prevented complete discussion. He touched briefly upon malaria therapy in cerebrospinal syphilis, which he declared to be extremely valuable for young, strong patients, who did not respond completely to other types of treatment. Malaria therapy, which may cause extremely severe, febrile reactions, is dangerous, and may be fatal where the age and general condition of the patient are unfavorable.

Cardiovascular syphilis must never be treated intensively. Pathological changes in the liver and kidney make necessary an extremely cautious approach. It is well to use mercury and iodides by mouth, with the addition subsequently of small doses of bismuth or mercury by intramuscular injections. In young people, where no contraindications exist, the use of neoarsphenamine may be expected to give important assistance. In answer to a question at this point, Dr. Rosen remarked that he never used sulpharsphenamine as he considered it unnecessary and dangerous by reason of its high toxicity.

Heredosyphilis is a severe type of infection. The spirochetes have been at work during the period of intrauterine development. Treatment is usually poorly understood and carelessly applied. There is a good chance for cure when properly managed. Treatment should be started within 2 or 3 weeks after birth. Frequently, there is no clinical evidence of the presence of luetic infection in new-

born infants, but, if untreated, there usually develops distressing mental retardation and interference with the special sense functions. Frequently, these patients require institutional care. Microscopic examination of the placenta is a more valuable diagnostic measure than the cord blood Wassermann. Where the cord blood Wassermann is negative, blood test made 6 or 8 weeks later may show a positive reaction. It is a good rule to treat all babies born of mothers known to have syphilis, unless the disease in the mother can be proven to be itself inherited. In treatment of these small patients, Dr. Rosen feels that intramuscular injections of mercury succinimide or neutral neo-salvarsan may be used. Small doses of ½ strength bismuth salicylate may be used also. If treatment is faithfully carried out over a period of 2 years, serological cure may be expected in 45% of the cases. To a question as to the treatment of syphilis in pregnancy, Dr. Rosen replied that the early recognition of the disease is important, and urged regular treatment as if the victim was not in the gravid state. He recommended 4 or 5 injections of bismuth followed by weekly doses of neoarsphenamine beginning with a dose of 0.3 grams, increasing the next week to 0.4, then to 0.5 as a maximum. One injection of bismuth or mercury should be given each week, a few days apart from the arsenic injection.

Personal Items

Dr. John Maher, of Long Branch, and Dr. D. F. Featherston and Dr. O. K. Parry, of Asbury Park, attended the annual meetings of the American College of Surgeons at Chicago in October.

Dr. Stanley Nichols, of Long Branch, Chairman of the Public Health Committee of the New Jersey State Medical Society, addressed the National Child Health Recovery Conference held in Washington on October 6, on "The Public Health Plan of the Medical Society of New Jersey and How It Can Be Used for the Purposes of the National Child Health Recovery Program".

MORRIS COUNTY

Marcus A. Curry, M.D., Reporter

A special meeting of the Morris County Medical Society was held the evening of Thursday, October 26, at the State Hospital at Greystone Park.

President Frost presided over an assemblage of about 35 members and guests; included in the latter were Dr. C. C. Beling, of Newark, Councilor for the First District; Douglas H. MacNeil, of the New Jersey Emergency Relief Administration; and Dr. Norman B. Tooker, Medical Consultant of the State Emergency Relief Aministration.

The meeting was called for the election of new members and for the consideration of subjects of immediate interest to the Morris County Medical Society, notably public health and emergency relief matters.

Four new members were unanimously elected, as follows: Dr. William Pottinger, Mountain Lakes; Dr. William K. Booth, Boonton; Dr. Forrest S. Chilton, Pompton Plains; and Dr. I. Norwood Griscom, Boonton.

Councilor Beling of the State Medical Committee on Medical Emergency Relief explained the working of the committee in relation to the State Emergency Relief Administration. Mr. MacNeil of the Relief Administration explained in detail the functioning of the organization with particular reference to relief clients. He answered a number of questions as to procedures with regard to the physician's authorization by the local director of Emergency Relief, hospitalization and the like. As this matter presented no pressing problem in Morris County, it was left with a committee of the Society to work out with the local Director of Emergency Relief in Morristown. Dr. Beling stated to the members that if the local medical committee meets with any difficulty, the state medical liaison committee stands ready to be of any possible assistance.

Public health matters were discussed in general. It was urged that problems of a medical nature should be returned to the hospitals and the physicians where they rightfully belong; that the proper place for the clinic is in the hospital.

President Frost described an ambitious and attractive program for the Society for the coming year, and urged the importance of a 100% attendance. He pointed out means of awakening habitual absentees to the opportunities thus presented to hear the outstanding speakers who are to address the Society.

After adjournment, refreshments were enjoyed in the hospital cafeteria.

PASSAIC COUNTY

Wayne W. Hall, M.D., Secretary

The annual meeting of the Passaic County Medical Society was held at Valley View Sanitorium, Thursday, October 12.

The nominating committee, consisting of Drs. McBride, Tuers and Vosburgh, recommended for officers the following candidates, who were elected unanimously: President, Harry S. Willard; First Vice-President, Wright MacMillan; Second Vice-President, Norman M. Dingman; Secretary, Wayne W. Hall; Treasurer, Leslie R. Taber; State Nominating Committee, J. V. Bergin; Alternate, John Carlisle.

The following applications for membership were received and placed before the Board of Censors: From Paterson, Drs. Irving Chrisman, Theodore Kinne Graham, Bertram M. Koenig, Louis Landaw, Joseph E. Mott, Robert A. Prince, Nicholas F. Scielzo, Francis L. Stouter, Jacob Allen Yager, Jack C. Warburton; from Passaic, Edward E. Edlkraut, Frank F. Jani, Anton P. Randazzo; from Montclair, Andrew Robert Mailer; from Clifton, Charles Keppler, Jr.; from Haledon, James S. Gallo; from Singac, Benjamin L. Steinberg; from Totowa, R. R. Schubert.

The Scientific Program was as follows:

(1) Diagnosis—Childhood Type Tuberculosis—Dr. W. L. Weintraub.

(2) Artificial Pneumothorax—with Review of 100 Cases—Drs. O. R. Hagen and E. L. Warren.

(3) Phrenic Neurectomy—Indications for Operation—with Review of Results in 75 Cases—Dr. Leon E. De Yoe.

(4) Thoracoplasty—wtih Review of 22 Cases—Drs. Norman M. Dingman and John N. Carlisle.

(5) Bronchiectasis—Diagnosis and Treatment—Dr. Wright MacMillan.

(6) Carcinoma of Lung—Presentation of Cases—Drs. O. R. Hagen, J. F. Gallo and Joseph Guarraia.

SOMERSET COUNTY

J. L. Young, M.D., Secretary

The regular monthly meeting, which was also the 117th annual meeting of the Somerset County Medical Society, was held October 12, at Bernards Inn, Bernardsville, N. J.

The meeting was called to order at 12:45 p. m. by the President, Dr. Flynn, with the following members present: Drs. Allis, Borow, Brittain, Cooper, Ely, East, Francis, Field, Flynn, Greenberg, Hegeman, Kay, Lawton, Levy, Lovejoy, Meigh, Pigott, Smalley, Stillwell and Sferra.

Guests present were Dr. Frank C. Johnson, New Brunswick; Dr. William C. Wilentz, Perth Amboy; Dr. William E. McCorkle, Ringoes; and Dr. Johnson, of Somerset Hospital.

The Secretary's report and the report of the Treasurer were read and approved.

The application of Dr. Ruth Earp, of Bernardsville, for membership was received and referred to the Board of Censors for consideration. Following their action, Dr. Earp was accepted as a member of the society.

Short talks were given by Dr. Wilentz, of Middlesex County, and Dr. McCorkle, of Hunterdon County.

Dr. Lawton moved that the dues be increased $1, such increase to be turned over to the County Treasurer. Motion seconded and carried.

The Nominating Committee recommended the following for officers for the ensuing year: President, F. McConaughy, Somerville; Vice-President, R. F. Hegeman, Somerville; Treasurer, A. A. Lawton, Somerville; Secretary, A. F. W. Sferra, Bound Brook; Reporter, J. L. Young, Somerville; Delegate to the State Convention for 3 years, A. A. Lawton; Member of Nominating Committee at the State Convention, D. S. Renner, Skillman.

Following the business meeting, the society adjourned to meet the Woman's Auxiliary in the dining room, where a delightful repast was enjoyed.

After dinner, the society was addressed by Dr. Johnson, of New Brunswick, on the subject of Public Health work.

Mr. Harry White, of Bound Brook, entertained the society by relating his personal experiences with Thomas Edison and Dr. William Steinmetz, with whom he worked for a number of years.

UNION COUNTY

St. Elizabeth Hospital

Elizabeth

At the Staff Standardization Meeting held at the St. Elizabeth Hospital on Thursday, November 2, Dr. Benjamin Gruskin, Director of Oncology and Experimental Pathology at Temple University School of Medicine, Philadelphia, Pa., gave a talk on "An Intradermal Test for Malignancy and Its Development".

The talk was discussed by Dr. Alexander Louria, of Long Island College, Brooklyn, N. Y.; Dr. Darlington, Professor of Pathology at Bellevue Medical School, New York City; Dr. S. Quinn, Chief of Staff at St. Elizabeth Hospital; Dr. A. Cassilli, Pathologist at St. Elizabeth Hospital; Dr. Pomerantz, Miss E. M. Cook, Dr. I. Lerman and Dr. G. Maksim.

Considerable interest was displayed by the physicians present, many of whom raised questions pertaining to various phases of the work. These questions were answered and discussed by Dr. Gruskin and Dr. Lourla.

Obituaries

HAMILL, Patrick J., M.D., a prominent physician of Jersey City, died of a heart attack on November 2, 1933, in his home at 306 Varick Street. He was born in Jersey City 51 years ago.

Dr. Hamill graduated from St. Bridget's Parochial School. In 1898, he received the degree of Bachelor of Arts at St. Peter's College, and in 1903 was graduated from the College of Physicians and Surgeons of Columbia University as a Doctor of Medicine.

After his graduation from medical school, he served 2 years at Gouverneur Hospital, New York, and was Chief of Staff at the time he resigned from the hospital to take up private practice here, in 1905. He was appointed Assistant Chief Surgeon of the Jersey City Hospital in 1916 under Dr. Gordon K. Dickinson. He was an orthopedic specialist at St. Francis Hospital, Jersey City, for 20 years, and had engaged in similar work at the Hamill Industrial Clinic on Journal Square.

During the World War he was Medical Director at the Federal shipyards in Kearny, N. J., and since had been on the medical staffs of several large insurance companies and industrial corporations, among them the Bethlehem Steel Corporation.

In 1917 he married Miss Mary A. Kenny, daughter of Edward Kenny.

Besides his wife, Dr. Hamill is survived by 3 sons and a daughter; 3 brothers, former Congressman James A. Hamill, now corporation counsel; Alexander S. Hamill, former President of the Board of Education; and Cornelius A. Hamill; and 3 sisters, Mrs. Isabelle H. Craven, Mrs. A. Meave Smith and Margaret C. Hamill, Principal of School 2. All live in Jersey City.

He was a life-long communicant of St. Bridget's Roman Catholic Church and was a member of St. Bridget's Holy Name Society. He also held memberships in Jersey City Council 137, Knights of Columbus; American Assembly, Fourth Degree, K. of C.; the Third Order of St. Francis, the Hudson County Medical Society, the Physicians' and Surgeons' Club of Hudson County, and Division 11, Ancient Order of Hibernians.

McKINSTRY, Franklin P., M.D., 78, died November 26, 1933, at his home at Washington, New Jersey. He had been a practicing physician there 54 years. Active in community affairs, he was an elder of Washington Presbyterian Church more than 35 years. He tutored 4 young men of the vicinity and each became a physician. He was a member of the Warren County Medical Society.

WAKELY, William A., M.D., of Orange, died on November 17, 1933, after suffering a stroke at his home, 120 South Main street, Orange.

He was born in New York State 70 years ago and had lived in Orange 42 years. He began as an associate of the late Dr. John L. Seward.

Dr. Wakely attended Oakwood Seminary in Union Springs, N. Y., was graduated from the New York Homeopathic Medical College in 1889, and was a member of the Essex County Medical Society. He practiced in Auburn, N. Y., and Far Rockaway, Long Island, before moving to Orange. He was a former Treasurer of the Metcalf Memorial Foundation in Orange.

Dr. Wakely leaves 2 sons, Dr. William E. Wakely, of South Orange, and George B. Wakely, of East Orange, and a sister, Mrs. Esther W. Paulin, of Geneva, Switzerland.

Greetings to the Profession



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Continued from Page V.

ties as their duty as Americans. He called attention to the unselfish and decisive part which the medical profession had played in the last war.

He stated that there were 4 especially outstanding and urgently *fundamental evils* that must be corrected before we can enter a better social order; viz., (1) the suicidal unwillingness of the world to lay down its arms; (2) the menace of predatory wealth, the inequalities of the distribution of wealth and the cruelty and injustice of our system which makes possible the crushing of the many for the enrichment of the few; (3) the dangerous and *very rapid* increase of the mentally and socially unfit, the sub-normal and the criminal classes, and our helplessness and apparent powerlessness to control or prevent lawlessness and crime, the correction of which, in his opinion, was entirely in the province of the Medical Profession; (4) the problems and tragedies of *over population* with its resultant misery of unemployment and its slow wearing down of the soul of our people, in the solution of which the doctors are especially adapted to play a large part.

Dr. Eagleton has also been to Richmond, Virginia, where he was the honor guest of the Southern Medical Association. He was invited to speak before the meeting. His subject was: "Certain Phases of Meningitis in Relation to Disease of the Petrous Apex".

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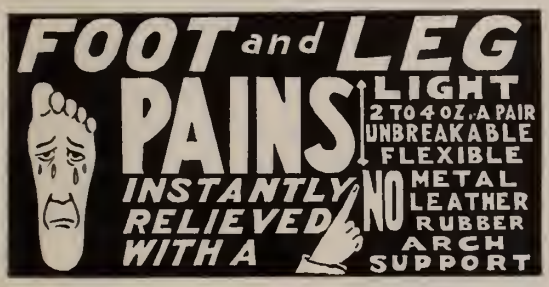
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